UNCTAD-WHO Joint Publication
**International Trade in Health Services**
**A Development Perspective**
Geneva, 1998

[Doc. symbol: UNCTAD/ITCD/TSB/5 - WHO/TFHE/98.1]

# 1. INTERNATIONAL TRADE IN HEALTH SERVICES: DIFFICULTIES AND OPPORTUNITIES FOR DEVELOPING COUNTRIES

**UNCTAD Secretariat**

## I THE NEW SCENARIO IN THE HEALTH SERVICES SECTOR

Governments are faced with a complex set of factors that continue to make it increasingly difficult to provide health services to their populations. In the developed world in particular high cost medical interventions combined with an ageing population have made the marginal health returns to many interventions extremely expensive[1]. The rate of globalization of trade, travel and migration, technology and communications has dramatically accelerated over the last two decades, resulting in gains for some and marginalization for others. Ecological problems have emerged with increased threats to health.

The World Health Organization (WHO) reports that although improvements in health status, health coverage and access to health care are apparent throughout the world, these improvements have not benefited all. In fact the number of the poor in developing countries has increased, thereby increasing the potential for health status disparities between the developing and the developed world. Projections indicate that there is a great danger that the gains realized cannot be maintained in the future.

It is increasingly being recognized that there is a significant impact of economic policies on health status. New policies tend to reduce government

[1] In 1995, the OECD countries devoted, on the average, 10.4 per cent of their GDP to health care (public and private). In the same year, they spent on the average US$ 2,071 per person on health care. In 1970 Medicare, the United States public health-insurance scheme for elderly and disabled, cost the government US$ 6 billion; in 1997 it costs US$ 200 billion. In future it will cost even more: by 2030, Medicare is expected to absorb 7.5 per cent of GDP, up from the current 2.6 per cent. In France total spending on public health has been surging at a real annual rate of more than 5 per cent over the previous 15 years. "A headache", *The Economist*, 8 March, 1997; "An unhealthy silence", *The Economist*, 15 March 1997, and "Will Medicare sink the budget?", *The Economist*, 1 February 1997.

spending on social sector programmes. If not counterbalanced, these policies can lead to detrimental effects on health status. Considerable concern has been expressed in recent years about the impact of economic development, and in particular the structural adjustment process, on both the environment and on social progress in general, especially education and health[2]. The increased acceptance of the multiplicity of factors that contribute to health status has resulted in attempts to develop intersectoral approaches. The health sector is seeking to interact with other sectors such as agriculture, education, economic, trade, and the environment.

As finances become more limited globally, the need to seek cost-efficient and cost-effective strategies for health systems strengthening and health care interventions is becoming more urgent. Competition between sectors can be expected to become more intense. Understanding the relevant benefits of an intersectoral approach and engaging the other sectors in developing coordinated programmes are necessary steps in the development of effective actions.

The environment within which health systems and health policy are being developed has changed dramatically. In previous decades governments looked forward to long periods of independence, national reconstruction, economic growth and a wider sharing of prosperity. "Redistribution with growth" was the theme for development. Economic orthodoxy and development thinking has changed. The redefinition and reduction of the role of the state are now being seen on all continents. Market mechanisms, rather than public intervention, are increasingly being used to drive national economies. The health sector is also experiencing these changes. There is growth in private sector participation in the financing, production and delivery of health and health care services. In some countries public institutions are being sold off to the private sector and new private institutions are replacing or augmenting them. Insurance schemes and community financing are being encouraged, as well as private providers. However, a new challenge will be for governments to continue to steer and regulate the health sector, including private providers, for the benefit of public health.

The changing balance between the public and private sector raises concern about equity and access to services especially of the most needy populations. Most governments are engaged in health sector reform initiatives and fundamental examination of the financing, organization and management of their systems. The search for new partnerships and sources of revenue is an integral part of these reforms.

The issues discussed above affect different countries in different ways. The capacity to address them depends in part on the socioeconomic and political environment of the country.

---

[2] J. L. Warford, *Environment, Health and Sustainable Development: the Role of Economic Instruments and Policie*s, Discussion Paper: Director-General's Council on the Earth Summit Action Programme for Health and Environment. Geneva, World Health Organization, 1994. p 16.

The key issues facing a number of poor developing countries include shortages of resources: financial, material and human. This is aggravated by adverse economic conditions and the loss of trained personnel to other countries. There is also a shortage of technology in many countries, and in others a concentration of high technology that serves only a small part of the population. Countries are searching for opportunities that will provide foreign capital and strengthen their ability to meet the needs of their populations. Among the opportunities being examined is a greater attention to opportunities for trade within the health sector. Countries are seeking areas in which they have a comparative advantage and using this as a basis for the development of services for export.

The competitive position of a health service will depend on many factors: the cost structure, the availability and skill level of human resources, service differentiation, availability of technology and health facilities. These comparative advantages are reinforced by other factors such as geographical proximity, cultural and linguistic affinities, natural endowments, and the ability to market the advantages effectively.

The benefits that may accrue from the development of trade opportunities must be weighed against the potential negative effects. For example, the development of a private facility with state-of-the-art technology to provide services for the wealthy or for foreign persons will increase the technology available in the health system. However, it is unlikely to contribute to the improvement of access to health services for the general population, unless arrangements are made that require a proportion of the beds or services to be available to the public sector. From a competitive point of view, the availability of technology is an important element to make a specific country/health establishment appealing. From a public health point of view, a right balance should be found between the need to invest in technology to guarantee a modern and effective level of health care, and the avoidance of overspending. It is clear that as countries explore opportunities in trade in health services there must not only be the corresponding regulations that enable this to take place, but more importantly legislation and regulations that support values of the national health policy such as equity and sustainability.

The General Agreement on Trade in Services (GATS) is the first multilateral agreement to provide a framework for regulating trade in services according to principles similar to those for trade in goods. It defines trade in services by the way in which they are supplied: by personnel providing services abroad, by consumption in other countries, through foreign direct investments, and across borders. In terms of GATS, health services include the general and specialized services of medical doctors; deliveries and related services, nursing services, physiotherapeutic and paramedical services; all hospital services; ambulance services, residential health facilities services, and services provided by medical and dental laboratories. In the multilateral negotiations, professional

services of doctors and nurses were differentiated from those of hospital services and negotiated separately.[3]

## II MODES OF TRADE IN HEALTH SERVICES

### Movement of natural persons

The temporary movement of personnel to provide services abroad is relatively more significant as a mode of trade in health services due to the essentially labour-intensive nature of these services, the fact that shortages of personnel exist in many countries and the fact that health services unlike many other professional services (e.g. legal, accounting services), are largely based on universal scientific knowledge.

Health professionals move to seek improved living and working conditions and more lucrative remuneration, often shifting from the public to the private sector. They also may wish to acquire higher professional qualifications or to expose themselves to new techniques not available in the home country. The employers seek to purchase skills that are in short supply domestically.[4] The movement of health professionals can remove shortages in the receiving countries, and remittances can improve the standard of living in the countries of origin. Thus, while the permanent emigration of health personnel can result in a brain drain from developing countries, the temporary movement can contribute to a general upgrading of skills when the returning persons resume their activities.

Developing countries are estimated to supply 56 percent of all migrating physicians and receive less than 11 percent[5]. The direction of flows has changed over time. Whereas, in the 1960s, doctors working abroad were mostly from developed countries, they now come predominantly from developing countries and particularly from Asia[6]. Many countries experience both an outflow and inflow of health personnel. For example, the United Kingdom exports junior nurses to the United States and in turn imports nurses (e.g. from India and Ireland) to meet domestic shortage; Jamaica exports nurses to the United States

[3]The services sectoral classification adopted in GATS broadly corresponds to the United Nations Central Product Classification, for which a new version has recently been adopted.

[4] Alastair M. Geray and Victoria L. Philips, "Nursing in the European Labour Market: an Economic Perspective", in C.E.M. Normand and P. Vaughan (Eds.), *Europe Without Frontiers: The Implications for Health*. Chichester, John Wiley and Sons Ltd., 1993.

[5] *The World Development Report 1993: Investing In Health*, quoted by: H. Ashok Chandra Prasad, Rajendar Kapoor, *Trade in Invisibles: An Indian Perspective.* New Dehi, Commonwealth Publishers, 1996.

[6] A. Mejía, H. Pizurki, E. Royston, *Physician and nurse migration*. Geneva, World Health Organization, 1979.

and imports them from Myanmar and Nigeria. Thus, the lowest income countries are the ones most affected by the "brain drain" as they are unable to attract replacements. For example, South Africa has witnessed an exodus of medical personnel to Canada, United Kingdom and United States, and also a migration from the public to the private sector within the country. The resulting shortage in the public sector was first met by personnel from neighbouring countries; however, as this was producing an unacceptable brain drain from its poorer neighbours, the South African government entered into contracts with Cuba to obtain medical personnel to work in more remote areas. In order to halt brain drain, an arrangement has been made for doctors from Mozambique to work part of their time in South Africa (while resident in Mozambique) so as to supplement their income. Often health professionals from developing countries are providing a great deal of the unskilled labour in the health sector in the developed world, despite the qualifications they may have.

Some recent studies draw attention to the saturation of developed country markets, especially the United States and the European Union, for certain categories of health professionals.[7] However, new openings may still be available in specific sectors, such as nursing care for the elderly and for people with disabilities or for patients suffering from drug or alcohol addictions, and medical services in remote areas. Cultural affinities and geographical proximity facilitate the movement of health personnel abroad.

### Actual or potential trade barriers

Restrictions to movement of health personnel may arise from economic needs test requirements, discriminatory licensing, difficulties with accreditation or recognition of foreign professional qualifications, nationality and residency requirements, state and provincial requirements, immigration regulations, access to examinations for completion of qualifications, foreign exchange controls affecting the repatriation of earning, or discriminatory regulation of fees and expenses.

Economic needs tests (ENT) condition temporary entry upon a determination that no resident/national of the host country is available and qualified to carry out the same assignment. In the GATS commitments, ENT, defined as a barrier to market access under Article XVI, frequently appears as a qualification to commitments relating to the movement of natural persons, including intracorporate transferees and independent contracted professionals. ENT acts as a quota restriction and may be qualitative or quantitative. ENT takes into account current population characteristics and health care service capabilities. Licensing provision can impede entry of foreigners through non-recognition of their professional qualifications or by imposing

[7] The United States Council on Graduate Medical Education has recently determined that by the year 2000 the national supply could exceed the need by more than 100,000 physicians. Quoted by Shalala Foreign Doctor Letter, 7 February 1997. Internet site: http://www.telalink.net/~gsiskind/docs/shalala.html.

discriminatory, more stringent and more costly standards on them. Licensing and recognition of qualifications is particularly complicated in cases where no national licensing body exists and granting of the licence to practice medicine is the responsibility of the individual state or provincial authorities, each of which has a medical licensing board. The requirement of registration with, or membership of, professional organizations could also constitute an obstacle to the person wishing to provide the service on a temporary basis.

In the United States, for instance, the requirements for obtaining a licence to practice medicine for those with qualifications obtained outside the United States vary from state to state, some of which allow graduates of foreign medical schools to practice subject to a written examination. Candidates must also pass the qualifying examination of the Educational Commission for Foreign Medical Graduates, and then undertake a period of graduate medical education at a hospital in the United States. Many states grant a licence to practice medicine by endorsement to graduates of accredited Canadian medical schools[8].

In Canada, the requirements for physicians with foreign qualifications to obtain a licence to practice medicine vary from province to province. Foreigners must also obtain the agreement of the relevant provincial ministry that their professional services are needed. Registered nurses must have been granted a provincial licence to practice in Canada before they can be granted entry as professionals. An employment authorization issued at the time of entry can have a maximum duration of one year. Extensions may be granted in one-year increments, at the discretion of an immigration officer. Under the North American Free Trade Agreement, provision is made for temporary movement of health professionals.

Within the European Union discriminatory treatment of nationals of other Member States based on nationality with regard to establishment and provision of services is prohibited. Several directives cover health service providers (Directive 77/452/EEC nurses responsible for general care, Directive 78/1026/EEC veterinary surgeons, Directive 80/154/EEC midwives, Directive 85/433/EEC pharmacists). Council Directive 93/16/EEC of 5 April 1993 relates to facilitation of the free movement of doctors and mutual recognition of their diplomas, certificates and other evidence of formal qualifications. It establishes provisions to facilitate the effective exercise of the right of establishment and freedom to provide services in respect to the activities of doctors, and provides for mechanisms of convergence and coordination. Proposals have been made to provide for examining the problems of nationals of the European Union (EU) with third-country medical qualifications[9]. Council Directive 89/48/EEC of 21 December 1988 provides for a general system for ensuring the equivalence of

[8] *World Directory of Medical Schools (* sixth edition). Geneva, World Health Organization, 1988.

[9] Commission of the European Communities, *Report to the European Parliament and the Council on the state of the general system for the recognition of higher education diplomas.* Brussels 15.02.1996, COM(96) 46 final.

university diplomas in order to bring about the effective freedom of establishment within the EU. Article 3 is the main provision of the Directive and establishes the general rule that a person who is entitled to exercise a profession in the member state of origin is entitled to recognition of a diploma for the purpose of taking up the same profession in the host state. Therefore it creates a right to recognition which individuals may rely upon directly before national authorities, both administrative and judicial. The system is based on the principle of mutual confidence and comparability of training levels. However, where major structural differences between training courses exist, the host Member State would be entitled to require compensation, namely the adaptation period and the aptitude test[10].

Although professional associations are crucial in maintaining standards and quality of service, they have often attempted to dampen price competition and restrict new entrants. For example, the American Medical Association used to provide for contract practice rules that made it unethical for a physician to treat patients under a salaried contract with a hospital or health maintenance organization (HMO) that was controlled by non-physicians. Association rules also considered it unethical for a physician to accept compensation that was inadequate in light of the usual fees in the community. Professionals have used control over medical plans or insurance firms to discriminate against potential competitors in the domestic market and abroad. However, restrictions imposed by professional associations are being eroded by market forces. It should be noted that some joint actions are legitimate and aim at maintaining standards and quality.

Lack of or incomplete information may discourage health professionals from looking for working opportunities abroad. In response to this problem, a number of specialized firms actively seek medical personnel for foreign destinations.

Regulations have often prevented health care professionals from advertising prices, discounts and services. Removing this restraint could be of importance in promoting competition; on the other hand, these regulations have been implemented with the aim of maintaining quality, compensating consumers for lack of information, and preventing deception and consumer injury.

**GATS commitments**

Most GATS commitments on temporary entry and stay of natural persons are not sector specific and therefore it is hard to evaluate how they will affect

[10] Some Member States have implemented legislation setting up rules on licensing and recognition of qualifications obtained in non-EU countries.

health care personnel[11]. The commitments on the movement of natural persons normally include entry requirements for three main categories of personnel - business visitors, personnel engaged in setting up an establishment presence, and intracompany transferee - and, a fourth category, namely personnel in specialty occupations. The fourth category could provide some limited access for health professionals, e.g. in the area of management consulting, research and development, or health educational services. Only a few countries, thus far, have made commitments in the area of personnel in specialty occupations.

Some of the trade barriers mentioned above are evident from the market access and national treatment limitations contained in GATS commitments. Moreover, temporary entry and stay of independent health care personnel are generally not covered by GATS commitments. A few commitments do provide for movement of natural persons in the medical and dental services, e.g. the EU under the sub-sector relating to professional services has scheduled commitments relating to (I) medical, dental and midwifery services (CPC 9312, 93191); (ii) veterinary services (CPC 932); (iii) nurses, physiotherapists and paramedical personnel (CPC 93191); and (iv) pharmacists. The commitments relating to (I) are covered both by the modes of supply relating to commercial presence and movement of persons. Under foreign commercial presence, some Member countries limit access to natural persons or professional associations among natural persons. Under the mode of supply of natural persons, residence or nationality requirements, ENT or limited authorizations apply[12].

The specific commitments on this mode of supply demonstrate that few countries have bound their existing immigration laws and regulations; there is

[11] For a an overview on temporary movement of natural persons see: *Information on the temporary migration regime (laws and implementing regulations) in force in selected developed countries.* Note by the UNCTAD Secretariat, UNCTAD/SDD/SER/7, 25 September 1995.

[12] Under foreign commercial presence it is provided that access shall be restricted to natural persons only in Germany and Spain. In Italy and Portugal access is also restricted to natural persons, however, professional associations among natural persons are permitted. In Ireland access can take place only through partnership or natural persons. In the United Kingdom the establishment for doctors under the NHS is subject to manpower planning. Under the mode of supply of natural persons, Denmark provides for limited authorization (for maximum 18 months) to fulfil a specific function and imposes a national treatment limitation providing for residence requirement in order to obtain necessary individual authorization from the National Board of Health. Italy also requires residency in the country. Greece, Portugal, Germany and France impose the condition of nationality. In France, however, access to non-nationals is possible within annually established quotas, while in Germany a waiver may be granted in cases of public health interest. Access for services provided by nurses, physiotherapists and paramedical personnel is provided for mainly through commercial presence and movement of natural persons. Under commercial presence, the EU schedule provides that in Austria, Italy, Portugal and Spain access for nurses is restricted to natural persons. Under movement of natural persons mode of supply, Denmark provides for limited authorization (maximum 18 months) to fulfil a specific function, Greece and Portugal provide for condition of nationality, and Italy for residence requirement and an ENT subject to regional vacancies and shortages. The above-mentioned limitations apply to non-EU citizens.

therefore some margin for improving the concessions without actually modifying the relevant legislation. In fact a number of countries have introduced provisions in their immigration legislation to facilitate the temporary entry of certain categories of medical personnel. In the United States, for instance, an H1A visa is granted to foreign nurses who are not immigrants and who occupy permanent positions temporarily; this visa does not require certification from the United States Department of Labor. A 1994 Act authorizes each state's department of public health to grant waivers for up to 20 physicians per year to work in areas having a shortage of health care professionals[13].

In Australia, of the 24 major classes of temporary resident visas and entry permits at least nine are relevant to the temporary entry of specialty personnel, including educational personnel, visiting academics, medical practitioners, and public lecturers. In Japan, in addition to persons setting up a commercial presence and intracompany transferees, employment permits temporary working visas to be issued to 13 categories of persons, including professors for research and teaching at the college-level; providers of medical services, and researchers. The United Kingdom has a regulatory regime for non-EU nationals that allows the issuance of work permits to licensed professionals, administrative and executive staff, highly qualified technicians with specialized experience, key workers with expert knowledge, and hospital auxiliary occupations. These categories are subject to a labour market needs test and, in the case of hospital auxiliary occupations, to quotas[14].

**Movement of consumers**

Trade in health services under this mode includes primarily health services provided to foreign patients; however, educational services provided to foreign students can also be considered as trade in health services.

*Patients* seeking health care in foreign countries could include (i) those who travel abroad looking for specialized and surgical treatments that employ advanced technology which may not be available at home or for prestigious health institutions; (ii) those who travel for convalescence care; (iii) those who travel to specific places to benefit from natural endowments - such as hot springs and spas - and are willing to link medical treatment with other activities, such as recreational tourism; (iv) those who travel for medical and dental outpatient treatment, looking for a treatment of similar quality to that they can receive at home, but less expensive or for specific services not available in the country of

[13] *Immigration and Nationality Act of the United States*. Washington D.C., Government Printing Office, 9th Edition, April 1992. Implementing regulations are summarized in *UNITED STATES Consolidated Federal Regulations*, 8- CFR Chapter 1. Washington D.C., Government Printing Office, 1.1.1994 Edition.

[14] *Trade in Labour Services and Temporary Movement of Persons as Services Providers*, Note by the UNCTAD Secretariat, TD/B/CN.4/24, 3 September 1993.

origin. Emigrants living abroad and border patients are important groups of clients; (v) elderly persons who move to countries where costs are lower and the climate is better than in the home country, and returning nationals who have lived many years abroad and who are able to retire in their country of origin. Retirees are regarded by many as the biggest potential market for developing countries; therefore the health care these countries are able to provide will affect their ability to attract the elderly. However, a major barrier to retiring abroad is the lack of portability of health insurances[15].

Elements such as well-developed transportation, common or similar language and culture, friendly doctor-patient relationship, readily available information on health facilities abroad, established links with health institutions in the home country contribute in all cases to making the option of health care in a foreign country more attractive. On the other hand, visa requirements, foreign exchange restrictions or the need to obtain authorization for medical expenditures may limit many patients from seeking services in foreign countries.

Countries which have traditionally attracted foreign patients are the developed countries which can offer health providers of international reputation, specialized treatment, and state-of-art technology. However, developed countries also compete among themselves on the basis of the fees they charge[16]. A number of developing countries are actively seeking to attract foreign consumers relying on their ability to offer good health care at prices significantly lower than in the developed countries. Others are trying to penetrate the international health service market on the basis of the uniqueness of the treatment they can offer or relying on their natural, geographical and cultural characteristics; however, these elements are usually combined with price advantages[17].

Until some years ago, the movement of patients was expected to expand, under the assumption that patients would increasingly request highly specialized care and that the number of health institutions able to provide it would be

[15] It is estimated that, by the year 2015, 15% of the United States' population, 24% of Japan's population and 17% of Europe's population will exceed 65 years of age. By 2015 the United States, Japan and Western Europe will have a combined population older than 65 years of age of more than 100 million. L. Martin, *The Graying of Japan.* Washington, D.C., Population Reference Bureau, 1989.

[16] Some world-renowned hospitals in Canada, for instance, have started targeting American patients. They can offer a service as good as the one provided in the United States at a fraction of US costs. This is because of cheaper administrative costs, much lower doctors' salaries, and a low Canadian dollar. "A Special Report with Radical Surgery". *Maclean's*, 2 December 1996.

[17] In the case of Mexico, for example, geographical proximity to the United States represents the major comparative advantage, along with lower costs, for developing health services exports. In addition, cultural factors in the border area - such as language and the special characteristics of the doctor-patient relationship - attract patient of Mexican descent and other Spanish-speaking patients who reside in the United States. In the case of Jamaica, an area of comparative advantage for the country is that it shares a common language with its main potential markets, the United States and several neighbouring Caribbean countries. In the case of India, most foreign patients come from countries having a large population of Indian origin.

limited. However, the trends in other modes of supply, especially commercial presence and cross border trade, as discussed below, may be reducing the motivations for patients to travel abroad, or may shorten the length of their stay in foreign countries.

On the other hand, the global trend of increasing medical costs and decreasing public health care budgets, with the consequent reduction of health care coverage, may encourage a larger number of patients to look for health treatment in countries where the ratio price/quality is more advantageous than at home. The effort to keep health costs under control may prompt HMOs in developed countries to include in their network developing country health institutions which can provide medical treatment at competitive prices. The reduction of public health coverage is leading to the expansion of private insurances, which may include treatment abroad[18].

The overcapacity in hospital beds in certain countries, notably the United States, has prompted major marketing efforts to reach potential foreign patients. Efforts by medical institutions, in countries where state-controlled medicine was previously the rule, to attract high paying foreign clients are beginning to have their impact.

### Actual or potential barriers

In the case of movement of patients, the most important barrier is the emotional insecurity of persons who are ill who do not wish to be far from their families and are particularly sensitive to cultural and linguistic differences. For those persons willing to travel to receive health care, an additional deterrent is the fact that in most cases the public health systems and the private insurance policies do not cover health treatment abroad (with the exception of some "de luxe" private insurance which include treatment abroad, but charge very high premiums, and of some insurances which cover health care received abroad in case of an emergency during business trips or vacations). This limits the current market for trade in the form of movement of patients to certain categories of consumers. Patients might, therefore, look for health care abroad if the treatment needed is not covered or not available, or is only partially covered by their health insurance. Since they have to pay for it, they may consider going where the ratio quality/price is more favourable than at home. Insurance coverage may be less of a factor when there are long waiting lists to have access to cover medical services, or when the patient feels that the quality of the health services provided by foreign institutions is significantly better than that provided by national institutions and is able and willing to pay regardless of insurance coverage.

[18] In the United Kingdom, for instance, the number of people covered by private health insurance has quadrupled in the past 25 years to more than seven million, corresponding to 12 per cent of the population. The private health market is expected to continue to grow at 5 per cent per year and treat 16.5 per cent of the population by 2000. "An unhealthy silence", *The Economist*,
15 March 1997.

The European Union has dealt with the problem of the nonportability of public health care insurance by a system under which sickness benefits in kind are provided according to the legislation of the country where a EU citizen resides or stays as if he or she was insured in that country. These benefits may be more or less advantageous than those provided by the country where the citizen is actually insured. After delivering the service, a bill is submitted to the health insurance of the home country for payment[19]. In some other countries (e.g. Costa Rica, Egypt, Jordan) patients can be authorized to obtain treatment abroad at the cost of the national health system (NHS) when the NHS are not in a position to provide the required treatment. However, procedures for authorization can be long and cumbersome. Some countries, including EU Member States, have signed bilateral agreements which allow a total or partial portability of the public health insurance

**GATS commitments**

In the GATS commitments related to trade in health services, consumption abroad is usually allowed without limitations. However, some countries (i.e. Bulgaria, Poland and the United Sates) have indicated restrictions on the coverage of public insurance schemes outside the country.

As *students* prefer to study in their own country to avoid future problems in certifying diplomas and obtaining licenses to practice their profession, this kind of movement of consumers takes place mainly for specific reasons. Examples are: when health education is not available in the home country; when the cost of medical or paramedical training varies greatly among countries; when students are unable to meet the qualifications of the domestic medical schools; or when they aim at achieving a higher level of education which could facilitate their access to the labour market of the country where they have studied or could allow them to increase their earning potential in their home country. In some cases foreign students become "residents" (postgraduate medical trainees who are delivering services), thus converting themselves from importers to exporters of services, while remaining in the same institution.

Usually, developed countries' strength to attract foreign students is based primarily on the international reputation of their institutions and/or on the uniqueness of the training they can offer. However, to an increasing extent, the cost is becoming a competitive factor. Some developing countries are also using the good reputation of their schools and/or of the special training they can offer,

[19] Other countries belonging to regional associations are trying to develop similar systems. In the case of MERCOSUR, for instance, a proposal which would allow citizens of one country to receive health care in another country under the same conditions applying to nationals of that country is under discussion. The main obstacle to the implementation of this proposal seems to be the lack of similarities among the national health care systems. Information collected in an interview with the Head of "Assessoria de Asuntos Especiais de Saude" in the Ministry of Health in Brazil in January 1997.

combined with the cost factor, as a means to attract foreign students. The ties established between foreign students and the hospitals where they undergo their study or training may become an important element later in patient referrals to such institutions from the students' home countries.

It seems that the most important criteria for choosing a foreign institution are its reputation, the cost, and the availability of funding. Other factors, such as language and cultural affinities and geographical proximity, also play a significant role. In certain cases it is the uniqueness of the training which attracts foreign students, such as the case of traditional Chinese medicine. The choice to go to abroad for education and/or training is also influenced by the extent to which the foreign diplomas are recognized by the home country[20].

Issues relating to the recognition of diplomas are usually very sensitive. One reason is the objective disparities in the curricula offered by different countries/institutions, another is the resistance of the health professional associations to open the domestic markets to students who have studied abroad, especially when there is no shortage of medical personnel trained in local schools. However, professional associations play a positive role in ensuring that health professionals comply with certain quality standards. Institutions which attract foreign students mainly because of low tuition prices and lack of screening during foreign students' enrolment risk being penalized if, at the same time, they are not able to give assurance on the quality of the education/training provided and the standards enforced in granting of degrees.

Some countries have a long tradition in providing education and training to foreign students (e.g. the United Kingdom[21] or the United States), while others have only recently entered into this market (e.g. Australia)[22]. Other countries, like China, which have traditionally provided education and training to foreign students in the framework of technical cooperation programmes, are now tending to do so on a commercial basis. However, countries such as Brazil

[20] In the case of institutions in China providing training in traditional Chinese medicine, for instance, the largest group of cash-paying foreign students are Germans, reflecting the fact that some German universities give credits for courses taken in specific institutions in China. In the case of Asia, joint ventures established between Australian universities on one hand, and Indonesian and Malaysian universities on the other, allow Indonesian and Malaysian students to attend half of their courses/training in Australia and half in their home country, having their diplomas recognized in Australia and at home. Information collected in several interviews with the managers of the universities of New South Wales and of Victoria in Australia in January 1997, and with researchers of the Research Institute for International Economic Cooperation of MOFTEC in China in December 1996.

[21] Eleven percent of the entire student body studying at higher education level at British publicly funded higher education institutions are foreigners. In the specific subject areas of "Medicine and Dentistry" and "Subjects Allied to Medicine", foreign students total to 13,300, of which 5,600 from EU countries and the remainder from non-EU countries, mainly Asia.

[22] However, foreign students studying in Australia represent already around 11% of the entire student body. Information collected in interviews with the managers of the universities of New South Wales and of Victoria in January 1997.

are still receiving foreign students mainly in the framework of technical assistance or other kind of agreements.

The flow of developing country students moving to other countries to study appears to be decreasing, since several developing countries have established medical and paramedical schools to meet national demand[23]. Moreover, the use of information technology, and in particular telemedicine, is affecting the movements of students, since they can use interactive educational services and upgrade their education without going abroad. However, while some years ago students in the health professions would concentrate in the area of medicine, dentistry or nursing, nowadays they may consider enrolling in new disciplines, such as health services management, or nursing administration. Since most developing countries are still unable to provide adequate education and training in these new areas, a number of students may consider going abroad for this kind of study/training.

**Foreign commercial presence**

This mode includes the establishment of a commercial presence in a foreign market to provide health-related services to clients in that market. It can be split into the following categories: (i) foreign commercial presence in the hospital operation/management sector; (ii) in the health insurance sector; (iii) in the educational sector; and (iv) on an ad-hoc basis.

In most countries foreign investment in the health sector has faced considerable restriction, if not prohibited. However, many countries have started opening their markets to foreign presence in various forms and favouring competition as a means to achieve better health services, reduce price escalation, and take pressure off the public sector. In addition, new business techniques have facilitated foreign participation with a minimum of actual investment.

*Foreign commercial presence in the hospital operation/management sector*. Hospital management companies usually try to establish themselves in countries which have liberal investment laws, are open to joint ventures, and have either high per capita income or a sufficiently large share of the population which can afford private health treatment.

It appears that most providers of health services have established themselves in foreign countries through joint ventures with local partners or triad ventures with local and third country investors. Acquisition of facilities is one technique of commercial presence but is restricted in many countries, management contracts and licensing are becoming a preferred means of commercial establishment for hospital services. The involvement of local partnership is usually sought so as to have access to certified and adequately

[23] *International Trade in Health Services: Main Issues and Opportunities for the Countries of Latin America and the Caribbean*. UNCTAD and Pan American Health Organization, UNCTAD/SDD/Ser/Misc.3, July 1994.

trained local medical personnel. Moreover, a local partner helps in ensuring local contact and commitments.

A significant characteristic of commercial presence in hospital operation/management is the involvement of companies whose traditional business lies outside health care services, such as management or pharmaceutical companies. This trend indicates that hospital operation/management is regarded as a growing sector and ideal for diversification. Another trend is to contract to an increasing extent non-health-related companies to carry out ancillary health services.

*Foreign commercial presence in the insurance sector*. Until recently, private health plans have seen little development abroad, in part because the market was limited, but also because in some countries there were regulations limiting or prohibiting private foreign investment in health insurance.

In Brazil, for instance, the health insurance market was opened to foreign capital and companies in May 1996, as part of the commitment of the Government to raise the quality of health services offered, to lower their prices and to establish a fair level of competition in the market[24]. However, the anticipated price decreases have not materialized, the main reason being that foreign insurance companies are not allowed to invest in hospitals, therefore the market is still characterized by very limited competition.

Another technique for penetrating foreign markets is through "managed care" services, which combine management and insurance. Managed care is a system that in varying degrees integrates the financing and delivery of medical care through contracts with selected physicians and hospitals and links with insurance companies (most HMOs are provided by large insurance companies) to provide comprehensive health care services to enrolled members for a predetermined monthly premium[25]. They, thus, create both captive suppliers and a captive market, but serve to reduce overall medical costs by requiring the participating physicians to provide the lowest cost treatment. In some countries, persons who would normally be unable to pay for private insurance can afford

[24] Since the opening of the market, four multinational companies have established themselves in Brazil, mainly creating joint-ventures with local companies. It seems that the presence of foreign insurance companies has already produced some improvements in the Brazilian market, namely, companies are offering insurance packages which provide a better coverage and are starting to save on administrative costs. Information collected in an interview with the manager of a consultancy firm specialized in insurances in Brazil in January 1997.

[25] The term "managed care" encompasses HMOs, preferred-provider organizations (PPOs), and point-of-service financing and delivery systems. HMOs are the most tightly structured variant of managed care, requiring patients to use participating physicians for medical care except in emergencies. PPOs are networks of individual physicians, medical groups, and hospitals that accept a discounted rate of payment in exchange for the plans, efforts to deliver large number of patients. Point-of-service plans are more restrictive than PPOs, but less so than HMOs in terms of the patient's ability to choose doctors. J.K. Iglehart, Health Policy Report. Physicians and the Growth of Managed Care. *The New England Journal of Medicine*, Vol. 331, No 17, October 1994. pp. 1167-1171.

the managed care plans, thus taking pressure off the public health sector. On the other hand the plans may lead to the defection of public doctors to the private sector. Managed care firms are resented by independent medical practitioners who fear a reduction in their autonomy, in their incomes and in the quality of medical treatment, but they find it difficult to compete with the managed care enterprises.

*Foreign commercial presence in the educational sector.* Some well-known medical schools are establishing themselves in foreign countries, including developing countries, usually through joint-ventures with local schools. This kind of foreign commercial presence is often accompanied by movement of providers (e.g. professors) and movement of consumers (e.g. students moving from the headquarters to the subsidiaries and vice-versa). The interest for the recipient country is to differentiate and upgrade the curricula available to its students/medical personnel, while the interest for the exporting institution is to have access to new sources of revenue, to spread its reputation abroad, and to avoid the overcrowding of its headquarters.

*Foreign commercial presence on an ad hoc basis.* Sometimes companies establish themselves abroad with the purpose of, for instance, upgrading health facilities within the framework of multilateral funding programmes. This kind of commercial presence is time-limited, since foreign companies usually leave the host country once the specific activities they were called to carry out have been finalized.

**Actual or potential trade barriers and GATS commitments**

According to their GATS commitments, all Member States of the European Union maintain some form of economic-need limitations on the establishment of new hospital facilities[26]. Moreover, almost every EU Member favours local over foreign interests in the establishment of a commercial presence. Less favourable treatment may be extended to foreign persons or entities with respect to acquiring real estate or investing in health care concerns[27].

[26]In France, Italy, Luxembourg, the Netherlands, and Spain, the construction or expansion of hospital facilities is limited by a health services plan that identifies local needs. Sweden maintains economic-need limitations on the number of private medical service practices that may be subsidized through its social security health care reimbursement system.

[27] In Austria, for example, foreign commercial presence commitments affecting all health care sectors require authorities to consider local interests before authorizing foreign persons or companies to acquire property and before allowing foreign concerns to invest in corporate entities. In France, foreign acquisitions of the stock of newly privatized companies may be limited if total foreign investment exceeds one third of total investment or 20 percent of total equity. In Finland, foreign commercial presence is allowed only through incorporation with a foreign equity ceiling of 51 per cent.

In the United States, the establishment of hospitals or other health care facilities may be subject to needs-based quantitative limits. Canada has not scheduled commitments on any health care services. Japan limits ownership of hospitals and clinics to national-licensed physicians or groups of persons of whom at least one member is a Japanese-licensed doctor. Moreover, investor-owned hospitals that are operated for profit are prohibited. Regulations are less strict in the nursing home sector where foreign companies are benefiting from a dramatic increase in the over-65-year-old population in Japan and a shortage of nursing homes and other long-term care facilities in that country[28].

According to the 1988 Constitution of Brazil, foreign companies cannot own hospitals or clinics. In Mexico, foreign investment is allowed up to 49 per cent of the registered capital of enterprises. In India, foreign companies can establish themselves only through incorporation, with a foreign equity ceiling of 51 per cent. Malaysia maintains economic needs tests. Foreign companies have to set up joint-venture corporations with Malaysian individuals or Malaysian-controlled corporations or both. Aggregate foreign share holding in the joint-venture corporations shall not exceed 30 per cent. However, some countries go beyond their commitments and actually allow more openness in their markets.

GATS commitments on "Life, accident and health insurance services" are most detailed under the mode of commercial presence. Cross-border trade is left “unbound” - i.e. no commitment has been made, therefore countries remain free to introduce any new measure regulating foreign service provision in the domestic market - in both market access and national treatment. Somewhat more liberal commitments are made for consumption abroad in market access, but not for national treatment, which is mostly left unbound. Among the many requirements for providing life, accident and health insurance services through commercial presence, the following are cited by most countries under market access commitments: limitations on foreign equity participation, requirements to provide the service with a specific legal entity; commercial presence; authorization and licensing requirements; limitation on the type of operations performed. A few countries have included such discretionary measures as economic needs test as well. In national treatment commitments are less stringent and conditions are mainly related to limited foreign share holding and nationality requirements.

The trend in both developed and developing countries is to open markets to domestic and foreign competition with the aim of reducing costs and improving quality so as to make the private health structure accessible to a number of people who cannot afford it at present. The switch of a part of the population from the public to the private health structures, with the consequent increase of human and financial resources available to the public sector, would be especially positive in those countries which suffer from a shortage of medical personnel and health facilities. A new challenge for the private and the public

[28] "United States International Trade Commission Investigation", *General Agreement on Trade in Services: Examination of Major Trading Partners' Schedule of Commitments*. (Investigation 332-358), Washington, 1995.

sectors is, thus, how to coexist in the same market benefiting from each other's presence. Some countries have already worked out arrangements to make sure that domestic and foreign private investments in the health sector are beneficial to the whole population[29].

The opening of markets to foreign insurance companies may also yield some positive results. It seems that domestic companies which have to compete with foreign companies are already improving - in terms of premiums, range of benefits, and conditions for enrolment - the insurance package they offer to their clients. If an increasing number of patients can join private health plans and a larger number of treatments are included in those plans, the consequence will likely be less pressure on the public infrastructure. However, a "new generation" of regulations may be required to ensure that foreign commercial presence is supportive of the national health system in the importing country.

**Cross-border trade**

Until recently cross-border trade in medical services, apart from licensing and royalties, did not seem to be feasible, particularly on a commercial basis. However, the recent rapid development in telecommunication technologies and health informatics has been dramatically changing the picture. Telemedicine, the practice of medical care using interactive audio, visual and data communications, includes medical care delivery, consultations, diagnosis and treatment, as well as education and the transfer of medical data. To a certain extent telemedicine is a substitute for face-to-face contact between health care provider and client as well as consultations between health care providers themselves. Other new developments in cross border trade include the processing of insurance claims/bills in developing countries, and offshore medical reporting.

One of the driving forces behind the recent provision and application of telemedicine services is their effect on cost inflation. According to studies in the United States, cost of telemedicine services could be expected to halve that of traditional services. Health care providers would be able to see a greater number of patients per day, particularly in cases related to home visiting, and this would benefit particularly understaffed health care institutions[30]

Currently, international trade in telemedicine services seems to take place amongst developed countries or is imported from developed into developing

[29]In India, for instance, the government may provide the land to build private hospitals in exchange for a certain number of beds for patients of the public sector. Information collected in interviews with the managers of the Apollo Hospital and the Scort Heart Centre in New Delhi, India, in January 1997.

[30] *Financial Times*, 5 February, 1997.

countries[31]. Among immediate benefits to the developing countries that accrue from the development of trade in telemedicine services are improved access to medical care and upgrading of the uneven quality of health treatments received in different regions and countries. Teleconferencing has been established among institutions in Canada, Kenya and Uganda for continuing medical education to allow health care workers in Africa to benefit from the latest medical knowledge and advances. Development of telemedicine could eventually have impact on other modes of supply of medical services: through receiving cross-border consultations patients will be less likely to travel abroad; medical professionals and students will be able to buy medical education services from foreign countries and will be less likely to move abroad. Telemedicine may facilitate the development across countries of consistent curricula and mutually acceptable professional standards.

The basic conditions that will further development of telemedicine over the next few years are the continued need for improving access and decreasing costs of health care, including elimination of money and time costs spent on travel of patients, physicians and nurses. With economic growth, ageing of the population, growth in attainment of education, emergence of new diseases and re-emergence and persistence of old diseases, the demand for medical services will be expected to grow substantially. Countries that will be able to benefit from telemedicine services most will be those that will have enabling technology and trained medical professionals to provide and receive it. On the other hand, lack of access to the development of telemedicine networks not only would deny potential benefits to local consumers, but also would marginalize health professionals in those countries which are unable to become part of the network.

### Actual or potential trade barriers

The existence of the enabling technology constitutes a critical element in providing some of these services: the substantial investment needed would make trade in telemedicine services prohibitively expensive in some cases. However, with the general trend of declining costs of equipment and communication links these aspects should be less acute in the near future. Several standards exist for transmitting data and images and for making electronic medical records, therefore compatibility problems could arise. Internationally agreed standards would enhance trade and comparability of care.

[31] Since the early 1990s telemedicine projects have been applied worldwide by WellCare Group as a Harvard Medical School initiative to provide national and international telemedicine services. The Well CareTelemedicine Network has set connections between the United States, Europe, Australia and Singapore and has offered telemedical services in a number of developing countries. Another example is Health Care International (HCI), located in Scotland, which is providing the world's first fully electronic patient care and completely electronic medical record. HCI receives referrals from health care providers in the Middle East, Greece, Turkey, Egypt, and the United Kingdom. M. Sosa-Iudicissa et al (Eds.), *Health, Information Society and Developing Countries*. Amsterdam, IOS Press, 1995.

Many problems, of technical and ethical nature, have to be overcome before telemedicine can be practised on a broad basis. Concerns remain regarding privacy of the patient in providing information on medical conditions, and steps should be undertaken to ensure patients' confidentiality.

The recognition of qualifications of the service provider and associated question of licenses to provide services across borders is also an issue. The question of ethical and legal liability associated with the provision of telemedicine services involves the dispersion of medical liability. Solutions similar to those in traditional medical services could be proposed by determining that the liability belongs to the practitioner who received the service (e.g. as in laboratory tests). More broadly, the regulatory framework has to be developed and legislation adopted before full-scale application of telemedicine can proceed.

Notwithstanding the favourable cost effect on patients' spending, telemedicine for the most part is not covered by the existing insurance schemes yet. However, fears that consumer unwillingness to receive consultations via telecommunications and their preference for direct face-to-face contact would limit provision of telemedicine were not supported by the early studies, where, contrary to expectations, technology acceptance was not a major issue.

### GATS commitments

More than half the commitments on cross-border trade were left unbound. It would be difficult to imagine that individual countries would impose restrictions on this type of trade, but issues of standards, liability, and recognition of qualifications would have the effect of limiting further development.

## III EXPORT STRATEGIES IN THE HEALTH SERVICES SECTOR

The development of exportable health services is seen as a means of: (a) contributing the resources required to reduce financial pressure on the fiscal deficit created by the need to grant universal coverage; (b) improving infrastructure (hospital facilities and other complementary structures) by utilizing the resources resulting from serving foreign demand, and (c) upgrading technological capacities with a direct impact on the national health system which can be assimilated and/or adapted to the existing human resources infrastructure. A crucial element of any successful export strategy is to benefit from the optimal use of forward and backward linkages between domestic production and the external markets of health care services.

Export strategies may be implemented by different actors: governments; public and private sectors; private sector associations; and individual companies.

*Strategies implemented by governments*. The rationale of this strategy is to obtain foreign currency from exports of health services in order to strengthen

the financial capacity of public health institutions and make the health sector a contributor to the global development of the country. Three key examples are Cuba, the United Kingdom and Jordan.

In *Cuba*, one of the government's objectives is to convert the country into "a world medical power." In this perspective, a multifaced export strategy in the health sector has been implemented since the end of the 1980s. One of the main elements of this strategy is to send medical personnel abroad, especially to countries which experience a serious shortage of health workers. Another is to attract foreign patients to specialized clinics which provide high quality health care at competitive prices. Most of the specialized clinics also function as training centres of medical schools for national and foreign students. Another facet of Cuban export strategy is to link health care with tourism. SERVIMED, a trading company created by the government, prepares health/tourism packages to be sold in target markets in cooperation with tour operators and travel agencies. Cuba also relies on service differentiation to make its health services competitive in the world market. Cuban doctors are able to treat with success some skin diseases which are regarded as incurable in the rest of the world. These treatments are associated with the development of new procedures and new drugs. The success of the Cuban strategy is proved by the increasing number of patients who go there every year for treatment. During the period 1995/96, more than 25,000 patients and 1,500 students went to Cuba for treatment and training respectively. As a result, income earning from the sale of health services to foreigners amounted to more than US$ 25 millions.

In 1988, the *United Kingdom* created the National Health System Overseas Enterprise (NHSOE), as the marketing arm of public health companies and institutions to facilitate the export of health services provided by the public sector. The rationale of the strategy is twofold. First, by exporting medical services, NHSOE is trying to strengthen the financial capacity of public health institutions to maintain and increase the coverage and standards of public health in the United Kingdom. Second, NHSOE provides development and care opportunities to British health professionals through their participation in overseas projects. The impact of this strategy has been positive, since public health institutions have been able to sell services overseas and obtain fresh financial resources. In addition, through the training and educational programmes, the NHS has partially overcome the shortage of medical personnel within the public sector, by facilitating the stay of foreign professionals.

*Jordan* has taken great strides since the beginning of the 1990s to become the medical centre of the Arab world. In this perspective, it has launched massive investment programmes to upgrade and modernize public hospitals and medical schools. It has, at the same time, created incentives for national and foreign private investment in the health sector. As a result of this strategy, eleven new private hospitals have started operations, most of them benefiting from state-of-art technology, including computerized links with prestigious health centres in Europe and North America.

*Joint strategies implemented by the public and the private sector. Australia* established the National Health Industry Development Forum (HIDF) in 1994 and implanted a programme of assistance to private firms, in an effort to bring various parts of the health industry together and help develop a common focus. The Forum is jointly convened by the ministries of industry and of health, with the support of Austrade. Australia's export strategy is focusing on two of the modes of supply, namely cross border trade and movement of consumers[32].

The public and the private sectors in *China* have jointly developed a strategy to attract foreign consumers, to export health providers and to set up foreign commercial presence, mainly based on the uniqueness of traditional Chinese medicine (TCM). Many of the foreign patients who go to China for treatment are "overseas" Chinese; however an increasing number of non-Chinese patients are showing interest in TCM. The movement of suppliers of services takes the form of health teams working abroad on contract - both in the framework of aid programmes or on a strictly commercial basis. Usually, Chinese institutions enter into agreements with foreign governments or directly with medical institutions. While they make a small profit, their main objectives are to upgrade the standards of medical services in China by exposing medical personnel to broader experiences and new techniques, and to disseminate the use of TCM abroad to benefit, in the long run, from a larger demand for TCM from patients in Western countries. China has also entered into joint ventures with partners in the medical profession as well as with local authorities and has opened several dozens TCM medical facilities in more than twenty countries. Most of them are the results of initiatives taken by specific medical schools, hospitals, or doctors, while others are operating under the auspices of the competent ministries. As from 1980, China has begun to take positive measures to open its medical and health market to foreign investment and allow joint ventures with foreign counterparts. By the end of 1996, sixty joint ventures with foreign partners were established in the hospital sector[33].

*Strategies implemented by private sector associations.* Private sector associations are implementing export oriented strategies to capitalize market opportunities. An illustrative example of a global strategy developed by a private

[32] Australia is aiming to become the centre of excellence in telemedicine by promoting and supportingR&D in the application of multimedia processes to deliver health care, taking advantage of its very developed infrastructure and low cost of telecommunications. The treatment of foreign patients encompasses the sale of private beds in public hospitals as well as in private clinics. To facilitate the flows of foreign patients to public and private clinics Australia has established a medical visa. Public medical schools are training foreigners in many areas of health. To meet foreign demand, Australian medical schools have created specialized international departments, set up joint ventures with foreign universities and opened medical schools in the target markets. As result of the above strategy, the incomes earned from overseas training activities contribute up to 20 percent to universities' budgets. The *Australian Health Care Industry*, Australian Health Industry Development Forum and Department of Foreign Affairs and Trade, June 1996.

[33] Xing Houyuan, The case of China. In this volume.

sector association is the one implemented by London Medicine[34]. It has two main objectives: promoting and developing business opportunities for London Medicine's affiliates in order to increase the flows of clinical, educational and research work in London's hospitals and medical schools, and to attract research contracts and investment from British and international companies.

Health cooperatives in the MERCOSUR countries have set up the *tarjeta MERCOSUR* which allows patients enrolled in the health cooperative of one country to receive health care in another country through the services of the associate cooperative.

*Private companies' strategies.* A number of health companies are developing global strategies to penetrate foreign markets taking advantage of promotional mechanisms implemented by their governments. This is, for instance, the case of the Parkway Group and the Raffles Medical Group of Singapore.

The Parkway Healthcare Group is the biggest investment group of health care in Singapore and one the largest health care organizations in Asia. The Group has created Gleneagles International as an international brand. A key element in the strategy of the company has been the acquisition of hospitals in Singapore, building up a base, and then stepping out into the region in joint ventures with partners in the host countries. Gleneagles currently has or is in the process of setting joint ventures in India, Indonesia, Malaysia, Sri Lanka, and the United Kingdom. The company is also setting up a specialized heart hospital in London. Another key element of the strategic directions of the group is to develop a highly integrated network of health companies in the region aimed at offering its patients a wide range of high quality and cost-effective health care services across Asia. The results of the strategy have materialized in Singapore where the three Gleneagles hospitals were the first in Asia to achieve ISO 9002 international quality certification[35]. Similarly, the Raffles Medical Group is building up strategic alliances overseas by developing triangular business associations with healthcare organizations from developed countries, to venture into third countries in partnership with host country investors.

Some private clinics in Canada are trying to exploit the American market, relying on the high quality of their services and on comparatively lower prices. A clinic in Toronto is negotiating with United States insurance companies and HMOs to offer medical services to their customers at a fraction of costs in the United States. This formula could lead to the unprecedented integration of Canadian and American health care[36].

---

[34] London Medicine was created in 1993 with sponsorship and support from London medical and business communities, as well as local and national authorities. *London Medicine Brochure*, July 1996.

[35] Singapore Trade Development Board, *Singapore Trade News*, March/April, July/August 1996.

[36] "A Special Report with Radical Surgery", *Maclean's*, op. cit.

## IV SUMMARY AND CONCLUSIONS

The health sector in almost all countries, including the most highly developed, is in the process of restructuring. In countries where health services were seen as a right for all, to be supplied, or guaranteed by the government, declining budgets and mounting costs have forced a reduction in government insurance coverage and opened up more scope to the private sector. This has increased the potential for international trade in health services. A number of developed countries have taken advantage of new trade opportunities in this sector.

Developing countries face an even more acute restructuring problem, sometimes as a result of conditions imposed by the IMF/World Bank programmes, this exacerbated by the fact that large segments of the population may have little or no capacity to pay for medical treatment and may have limited access to medical care. For some developing countries trade in health services is regarded as a means of increasing revenues and strengthening and upgrading their national health service. In doing so they are drawing upon competitive advantages which include lower cost skilled personnel, cultural factors, natural endowments, and unique forms of medicine.

The movement of natural persons is of particular importance as a "mode of supply" of health services. The movement of medical personnel seeking higher income or higher quality living and working conditions can give rise to export earnings in the form of remittances, but can also result in a "brain drain" in countries where the same opportunities are not available. In many countries, the outflow of nationals is compensated by the inflow of foreigners. Unfortunately the poorest countries, including least developed countries, find themselves most penalized as they are unable to obtain replacements. The countries which seem to gain the most from export through this mode are those which organize such movement in teams which both create export earnings and ensure that the personnel return to their home countries bringing with them increased skills. Paradoxically, the immigration regulations may be drawn up to facilitate the entry of medical personnel, who face difficulties in practising due to the lack of recognition of professional qualifications. The establishment of consistent curricula and mutually acceptable professional standards among countries may be a necessary step to facilitate the movement of health professionals in the future.

The movement of persons as consumers is growing and taking different forms, no longer being confined to wealthy persons in developing countries seeking specialized treatment in developed countries. Developing countries are evolving strategies to attract foreign patients. While the main barrier may be the inherent insecurity of unhealthy persons, the nonportability of insurance policies (government and private) internationally limits the size of the tradeable market.

The export of medical education services, once the reserve of a few developed countries, is now becoming an important trade item for certain developing countries. Often the students become medical residents, delivering

services in the country in which they are studying, thus converting themselves from importers to exporters.

The establishment of foreign firms in the health sector has traditionally been prohibited or impeded by a variety of restrictions, including economic needs tests. However, the enlargement of the private health sector has been accompanied by a partial opening of the market to foreign firms in many countries, often with a view to reducing costs, relieving the burden on the public sector, and introducing new technologies.

The penetration of foreign markets is being facilitated by the emergence of new forms of business organization such as HMOs. These have exercised downward pressure on health costs.

Telemedicine is making trade in health services possible through the "cross border" mode. Telemedicine can be used to provide medical services to poor countries and remote regions within countries. Some commercial firms are basing their export strategies on telemedicine.

The increasing globalization of the health service sector is an indication of the expansion of trade through all four modes of supply. Deeper liberalization has been taking place within regional and sub-regional agreements. Regulations and restrictions imposed by governments and private professional associations are being eroded by market forces. However, many restrictions still exist to international trade in this sector, as witnessed by the relatively limited GATS commitments in this area.

Many countries, both developed and developing, are adopting export strategies for health services, and some are liberalizing access to their own markets. However, the limits to competition presented by social, cultural and development considerations, observed in many service sectors, are more acute in the health service sector where the lives of individuals and the wellbeing of the population in general, are at stake. A "new generation" of regulations needs to be devised to permit increased trade in this sector as a means of reducing costs while ensuring that such trade strengthens the quality and coverage of health care.

A number of additional factors which affect the capacity of developing countries and their trade performance in the health service sector would seem of similar relevance in other service sectors, such as the importance of movement of persons, not only as a means to supply services but also to upgrade skills and technological capacity. In addition, new trade opportunities are provided by emerging technologies which facilitate cross-border trade and the new forms of business organization for penetrating foreign markets. However, they also pose difficulties in drawing up regulations and scheduling commitments which foresee such development. In addition, they illustrate the need to exploit the potentially mutual supportive role of the public and private sectors and the importance of the current work under GATS on the mutual recognition of professional qualifications.

Trade in the health services sector also demonstrates the vulnerable position of poorer, especially least-developed, countries which, on the one hand, suffer from brain drain and, on the other, do not have access to advanced

technologies. Direct action by the international community is needed to prevent a further erosion of their capacity, in health and other services sectors.