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Trade in Health Services

What's in it for Developing Countries?

Olivier Cattaneo

The World Bank
Poverty Reduction and Economic Management Network
International Trade Department
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Abstract

This study summarizes the existing knowledge and relevant abstracts and case-studies on the design of health and/or trade reforms and policies. The study aims to contribute to the understanding of the potential benefits and risks—and ways to maximize the former and minimize the latter—of trade in the health sector. It is designed for non-trade (health) experts to understand how trade can help to improve health systems and access to health services, and for trade specialists to understand the specific characteristics of the health sector.

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TRADE IN HEALTH SERVICES: WHAT'S IN IT FOR DEVELOPING COUNTRIES?

Olivier Cattaneo
World Bank

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TRADE IN HEALTH SERVICES:
WHAT'S IN IT FOR DEVELOPING COUNTRIES?

Trade in health services in a nutshell

A number of countries are competing to become key exporters of health services. In particular, the growing phenomenon of health tourism appeals to many developing countries where clinics servicing foreign clientele flourish. An increasing number of countries offer attractive surgery, recuperation and rejuvenation holiday packages, from South Africa or Costa Rica to Thailand or India. On the demand side, the US remains the largest consumer of health services worldwide. Deloitte Consulting (2008) estimated that 750,000 Americans went abroad for health care in 2007, with a projected growth rate of 100 percent from 2007 to 2010, to reach six million outpatients in 2010. On the supply side, developed and developing countries are competing: over 35 countries serve more than a million medical tourists annually. In 2008, more than 400,000 non-US residents sought care in the US and spent almost USD 5 billion for health services; they were 1.2 million in Thailand, 450,000 in India, 410,000 in Singapore, and 300,000 in Malaysia. Motives behind the cross-border movement of patients do vary a lot, however, and not all countries compete on the same market segments: there is a case for specialization in market niches on the basis of each country's resources and trade opportunities.

Medical tourism has received significant media coverage and attention. However, trade in health services is not limited to the cross-border movement of patients, which represents only one of the four possible modes of services delivery identified by the General Agreement on Trade in Services (GATS) – mode 2 (see Table 1). Other key components include the temporary movement of health professionals to deliver services across borders (mode 4, e.g., cross-border movement of doctors and nurses), foreign establishment (mode 3, e.g., the opening of a branch of a clinic in abroad), and the cross-border provision of health services through technological means (mode 1, e.g., telemedicine). In addition, a number of other services and goods are traded at the margin of health services: it is a common characteristic of many services that they enable trade in other sectors.

Trade in health services potentially has significant effects on the availability of these services, the quality of the health system, and the population's health at large in both the exporting and the importing countries. Effects of trade in health services also considerably vary from one mode of delivery to another, and imports often appear more important than exports to improve one country's domestic health system. An excessive enthusiasm for medical tourism that is not backed by serious business plans or coherent government policies could result in a low return on investment, lead to frustrated expectations, and prejudice local supply of health services. Not all countries have a comparative advantage in health services trade. While a carefully designed trade strategy in the health sector could have significant positive spill-over effects on the domestic supply and access to health services (in addition to the global positive impacts of trade), a poorly designed strategy could divert already scarce resources from developing countries' peoples in need.

Health is not any commodity or service; it is a public good. Trade in health services could directly contribute to reaching – or missing, if negative effects prevail – health-related Millennium Development Goals.[1] Trade objectives in the health sector should be compatible with other

[1] Millennium Development Goals pertaining to health include: MDG 4 (Reduce by two thirds the mortality rate among children under five), MDG 5 (Reduce by three quarters the maternal mortality ratio; Achieve,

legitimate social objectives (e.g., universal access). Health is also a highly regulated profession; here again for legitimate purposes: even more than other professional services, medicine is characterized by the asymmetry of information between the service provider (doctor trained to the practice of medicine) and the patient (seeking treatment). Regulation of the health sector is necessary to protect patients against malpractice. Trade promotion in the health sector is therefore not about deregulating, but better regulating, and sometime even regulating more, e.g. to adopt higher quality standards for hospitals and clinics. Similarly, trade promotion is not about challenging the public health sector, which often plays a crucial role in the supply of health (and medical education) services, but about designing efficient services in a more competitive environment. Experience shows that public involvement is often necessary to the success of export promotion strategies in the health sector. Nonetheless, private investment (including foreign investment) remains a crucial factor of success, in particular where public resources are too scarce to maintain an efficient health system.

Table 1. What do we mean when we talk about trade in the health sector?

	Trade in health services	**Trade in ancillary services**	**Trade in goods associated with health services**
Mode 1 **Cross-border Supply**	- Tele-medicine, including diagnostics, radiology	- Distance medical education and training - Medical transcription, back office - Medical research tools and databases - Medical insurance	- Health care equipment - Drugs - Medical waste - Prosthesis
Mode 2 **Consumption abroad**	- "Medical tourism", i.e. voluntary trip to receive medical treatment abroad - Medically-assisted residence for retirees - Expatriates seeking care in country of residence - Emergency cases (e.g. accident when abroad)	- All activities associated with health tourism (e.g. transport, hotel, restaurant, paramedical, local purchases, etc.) - Local medical education and training of foreign nationals	
Mode 3 **Commercial presence**	- Foreign participation or ownership of hospital/clinic or medical facilities (e.g. capital investments, technology tie-ups, collaborative ventures)	- Foreign-sponsored education or training centers - Foreign-sponsored medical research facilities	
Mode 4 **Presence of natural persons**	- Movement of doctors and health personnel for the purpose of commercial medical practice	- Movement of doctors and health personnel for other purposes (e.g. education or training)	

Sustainability of public health insurance schemes, ageing of the population, and related-supply bottlenecks in the health system are among the drivers of frustrations and outbound medical tourism in the North. Most developing countries face far more critical health issues: critically low medical density, poor quality of the infrastructure and services, etc. that combined with other factors result in poor public health and higher mortality rates. In all those countries, trade in

by 2015, universal access to reproductive health), and MDG 6 (Halt and begin to reverse the spread of HIV/AIDS; Achieve, by 2010, universal access treatment for HIV/AIDS for all those who need it; Halt and begin to reverse the incidence of malaria and other major diseases).

health services should not only be seen as a source of income in the balance of payments, but primarily as a means to remedy shortages and improve domestic health systems. Therefore, the main challenge will be to find adequate accompanying policies that aim to maximize the positive domestic spillovers and minimize the negative domestic spillovers of trade in health services.

Also, the focus of media and many expert studies has been mainly on North-South (when it comes e.g. to the movement of patients) or South-North (when it comes e.g. to the movement of doctors and nurses) trade. The potential of South-South trade has often been ignored or neglected, in sharp contrast with the reality of trade: in Tunisia, for example, Libyans represent more than 80 percent of the foreign medical patients; similarly, more than 80 percent of the Omani patients treated abroad went to India. There is a case for further cooperation in the South, e.g. for the creation of regional health centers of excellence (for medical education and/or treatment) that would help sharing the cost of medical education and infrastructure and reaching a critical size for writing off investment in technologies.

There are a number of studies that extensively cover the topic of trade in health services (see e.g. Bloui, Drage, and Smith, 2006). The ambition of this paper is more modest: it is an effort to summarize existing knowledge and to select most relevant abstracts and case-studies that could help any individual or organization involved in the design of health and/or trade reforms and policies understanding the potential benefits and risks – and ways to maximize the former and minimize the latter – of trade in the health sector. It is designed for non-trade (health) experts to understand how trade can help improving health systems and access to health services, and for trade specialists to understand the specific characteristics of the health sector.

The first section of the paper explores what a country could expect from increased imports and/or exports of health services, and what accompanying policies may be needed to maximize the benefits and minimize the costs of opening. The second part briefly outlines strategies to foster trade in the health sector that combine domestic reforms and offensive trade negotiations.

1. WHAT TO EXPECT FROM INCREASED TRADE IN HEALTH SERVICES

The impact of trade on countries' health systems may vary a lot according to various factors, including the mode of services delivery, the structure of the domestic market for the provision of health services, and the adequacy of accompanying regulations and policies. In other terms, trade in health services may create opportunities and have a number of benefits – not only for the business partners involved in trade, but for the population as a whole, but it could also potentially have a cost and negative effects. This section of the study reviews those effects, and suggests solutions – on the basis of country case-studies – to maximize the positive and minimize the negative spill-over effects of trade. It also stresses that the common tendency to protect the domestic market against imports could prove particularly damaging in the health sector: imports are just as important as exports – if not more important. Given that the four modes of services delivery are intertwined, it could also prove a vain attempt. For example, a country that does not allow foreign investment in the health sector or does not allow foreign doctors to practice locally, might be able to limit its imports under modes 3 and 4; this policy is very likely, however, to result in higher imports under mode 2, since a number of nationals will seek treatment abroad to access a certain quality of care (technologies and internationally reputed doctors); this would create further inequalities in access to health care, and money spent on health care abroad would never benefit the domestic system – unlike, potentially, foreign investment or the domestic practice by a foreign doctor.

Successively, this section analyses the impact of trade from the perspective of the importing and exporting parties, underlining potential threats and opportunities, and ways to minimize the former, and maximize the latter.

Who is the exporter? Who is the importer?

Under **mode 1**, the exporter and the importer do not move across borders – the service only crosses the border:
- A patient in country A (importer) receives treatment from a doctor located in country B (exporter).
- A hospital in country A (importer) outsources transcription services in country B (exporter).

Under **mode 2**, the importer moves across the border toward the exporter:
- Country A (importer) sends patients for treatment in country B (exporter).
- A tourist from country A (importer) received treatment while traveling to country B (exporter).

Under **mode 3**, the exporter moves across the border toward the importer:
- Country A (importer) authorizes the establishment on its territory of a medical facility partially owned – and eventually operated – by a healthcare provider from country B (exporter).

Under **mode 4**, the exporter moves across the border toward the importer:
- Country A (importer) authorizes a health professional from country B (exporter) to practice medicine on its territory and on a temporary basis.

1.1. The import side: Using trade to improve domestic access to better quality health services

Most countries, in particular but not exclusively in the South, suffer from shortages in the health sector (human and/or capital). Increasing imports, through foreign direct investment or other channels, could contribute to remedying these shortages, although it could present some challenges for countries where private participation to the provision of health services has been deliberately limited. Indeed, there is a case for increasing some types of imports provided adequate accompanying measures are taken.

- **Benefits (realized and expected) from imports**

The benefits of imports will vary according to the mode of services supply, and according to whether the service is provided/consumed locally (e.g. imports under mode 3) or abroad (e.g. imports under mode 2), in other terms, whether the money spent benefits the domestic (minus leakages) or a foreign health system.

Mode 1

Telemedicine remains underdeveloped. One could imagine that the benefits would be the same as for mode 2, without the inconvenience associated with travel (i.e. the same benefits available to more people). These would include: the alleviation of some human and infrastructure resources constraints, in particular in remote and underserviced areas, and broader access to higher quality personnel, diagnosis and treatment. Same as under modes 3 and 4, one could imagine that trade under mode 1 would promote knowhow and technology transfers.

With regard services such as medical transcription, trade reduces the cost of operating medical practices, and therefore makes access to medicine theoretically more affordable.

Mode 2

The treatment of patients abroad helps alleviating some of the domestic human and infrastructure resources constraints. The case of Oman (case-study n°1) is typical of a developing country with

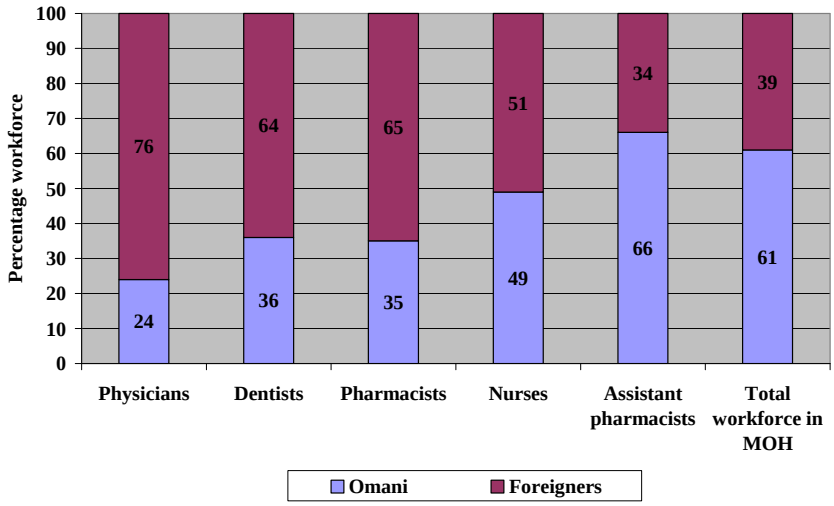
low medical density that needs to send patients abroad, at least in the short term, until adequate treatment is provided locally. In Oman, and in a number of other countries, the travelling patient can seek reimbursement if the treatment is not available locally. This sponsoring is very costly, however, and not all countries can afford such schemes. In addition, in many developing countries, medical travel remains driven by a lack of confidence in local health care providers, and remains perceived a luxury rather than a necessity.

In countries, mainly in the North, where treatment is more expensive than in competing health services provider countries, imports under mode 2 could ease some tensions on health insurance systems and make them sustainable. According to Mattoo and Rathindran (2005), the healthcare system of the US would save USD 1.4 billion annually if only one in ten patients were to go abroad for a limited set of 15 highly tradable, low risk treatments.

Case study n°1:
Remedying Health Shortages Through Trade under Modes 4 and 2 – The Case of Oman

Oman is an upper-middle income, resource-rich, and labor-importing country. The health sector is no exception, and Oman is a net importer of health workforce. In 2003, the Ministry of Health employed 18,558 professionals, of whom almost 40 percent were foreigners – up to 76 percent of the physicians. Most health administrators are Omani nationals. The same year, there were 2,838 health professionals employed in the private sector, and 95 percent were foreigners (mostly from India, Egypt, Pakistan, Philippines, Sudan, and Iraq).

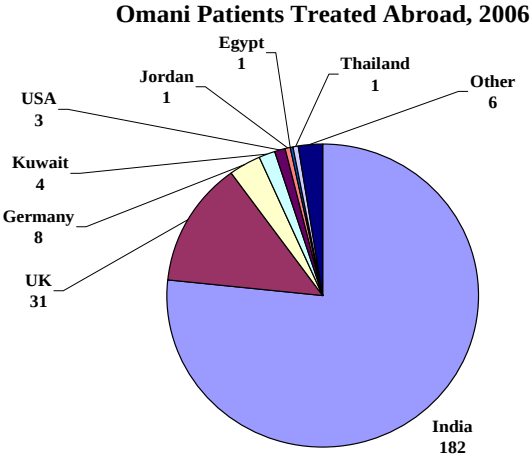
Foreign Professionals Working in the Public Health Sector in Oman



Source: WHO

Despite these significant imports, the Omani health sector still falls below international benchmarks with a density of 12.6 doctors, 31.6 nurses, 0.7 pharmacists, and 0.7 dentists per 10,000 inhabitants (MOH, 2006). Therefore, Oman has to supplement these imports under mode 4 with imports under mode 2, i.e. send some of its patients for treatment abroad. Accordingly, there is an official policy to sponsor Omanis for treatment abroad if not available locally. The average annual cost was USD 3 million for 2001-2003. The number of patients treated abroad has dropped from 418 in 1990 to 237 in 2006 due to public investments in the sector. In 2006, 44 Omani patients were treated for neoplasm abroad (compared to 180 in 2000), 58 for orthopedic diseases, 39 for cardiac diseases, and 31 for ophthalmologic diseases. Targeted public investment can help significantly reduce the cost of these healthcare imports. For example, government-funded medical travel for oncology fell by 92 percent from 2004 to 2005 after an oncology center opened.

At the margin of healthcare services, Oman also imports medical education services under Mode 2: in 2003/2004, 1,341 medical students received foreign training – 52 percent were government sponsored, and 48 percent self-sponsored.



Source: MOH of Oman, 2006

Source: Suleiman (2005) and Ministry of Health of Oman (www.moh.gov.om)

Mode 3

Foreign investment plays a crucial role in many parts of the economy, both in developed and developing countries. However, due to the structure of many health systems, the role of the public sector in health, and the difficulty to articulate public and private interests in the provision of health services, foreign direct investment (FDI) in the health sector has remained underdeveloped in many countries. Potential gains are nonetheless important and should not be neglected.

Foreign investment could bring new resources to the health system, foster competition among health services providers (raising standards, quality, and lowering prices), and encourage technology and knowledge upgrades and transfers (e.g. training of medical and management personnel, or economies of scale on medical supplies). It could reduce the burden on public spending, including by reducing the need for sponsoring expensive treatments abroad, and create more jobs. The case of India (case-study n°2) perfectly illustrates these effects (and their limits).

It should be noted that the provision of health-insurance services (primarily through modes 3 and 1) by foreign companies also could have an important impact on the sustainability of the domestic health systems and facilitate access to health services.

In India, for example, Hindustan Latex Ltd and Acumen Fund (USA) created a joint venture to develop a small chain of high-quality and affordable (30-50 percent of regular price) maternity hospitals designed to serve the low-income population of underserviced Indian regions. Initiators of this initiative hope it could serve as a global model for increasing access to qualitative and affordable health care for the world's poor.[2]

[2] See http://www.lifespringshospitals.com.

Case Study n° 2:
Remedying Health Shortages Through Trade under Mode 3 – The Case of India

The Indian healthcare delivery market is one of the largest service sectors in the economy (estimated USD 18.7 billion and 4 million jobs) that has grown at about 13 percent annually in recent years. Nonetheless, India's health sector still falls well below international benchmarks – including in comparable developing countries – and **needs to scale up considerably in terms of the availability and quality of its physical infrastructure and manpower**. Given the growing demand, the significant and growing role of the private sector in healthcare delivery and expenditure (75 percent of total healthcare expenditure, with public health expenditure accounting for less than 1 percent of GDP, compared to an average 3 percent in developing countries, and 5 percent in developed countries), and the huge investment needs, there has been growing interest among foreign players and non-resident Indians to enter the Indian healthcare market.

The Indian foreign investment policy is very liberal for hospitals, and foreign investors do not face major regulatory hurdles to entering the Indian market. Some 90 FDI projects in hospitals and diagnostic centers have been approved during the 2000-2006 period, for a total of USD 53 million, and covering both developed (Australia, UK, US, Canada) and developing countries (UAE, Saudi Arabia, Malaysia, Singapore, Mauritius). This list, however, does not include the well-known corporate hospitals in the country (identified projects were small or mid size hospitals, within the 1-2 million dollar investment range), and FDI sometimes is received only for routing purposes (e.g. a promoter company based in Mauritius for tax benefits only). Overall, **it appears that foreign investment in Indian hospitals remaines limited, notwithstanding the liberal regulatory framework.** According to one estimate, foreign investors have tapped only 10 percent of the Indian healthcare market.

It is perceived that there will be increased inflow of foreign funds into India's hospital segment in the near future, with major expansion plans by existing and prospective corporate players. These include huge **medical cities** with large super-specialty or multi-specialty hospitals and integrated healthcare services as well as scaling up of existing operations and setting-up of new hospitals around the country. While there are several prospective players in the Indian hospital market (e.g. Dubai, Singapore, the International Finance Corporation), the main source countries for FDI are anticipated to remain the US, UK, Australia, and Singapore. It is also recognized that **large investments (USD 100 million or more) can only happen through investments in corporate hospitals (chain)**, and that India would take some time before it can replicate the developed country model of very large corporate chain hospitals given the average size of hospitals in those countries is several times that of some of the largest hospitals in India (e.g. 10,000 versus 2,000). **Reputation and brand value are key** to accessing funds through private equity, foreign institutional investors, or external commercial borrowing. Hence, new hospital projects would primarily have to rely on domestic debt and would not see much foreign capital inflows except through individual non-resident Indian investors or through groups of small investors.

A further analysis of the reasons for the limited presence of foreign investment in Indian hospitals reveals **a number of external and domestic constraints**. These include the fact that the number of foreign players is limited, there are many competing investment destinations, and there are difficulties for foreign players in entering independently and in maintaining joint ventures. In addition, the gestation period in hospital projects is long and investors may not be willing to make such a long term commitment. More importantly, various domestic factors adversely affect the returns to investment in hospitals in India: high initial establishment costs (e.g. prohibitive cost of procuring land), low health insurance penetration in the country (i.e. smaller consumer base for corporate hospitals), restrictions on medical training and providers (i.e. supply bottlenecks and adverse effects on the quality of the personnel), high cost of importing medical devices (and a limited domestic manufacturing capacity in this area), other regulatory deficiencies (e.g. lack of standardization, proper governance, and quality assurance), and lack of policy clarity and priority to the healthcare sector. Thus, **the Indian experience shows that a liberal foreign investment policy is not enough to secure a strong foreign participation in the hospital segment**.

Looking at the impact of foreign investment in hospitals in India, it has been observed that:
- Foreign funded hospitals are likely to focus on more advanced procedures and specialty areas;
- They are more likely to focus on curative and intervention oriented treatment than on preventive and long-term kind of treatment;
- They are likely to employ a higher ratio of technology to personnel in their healthcare delivery and thus involve a substitution of human resources with technology and equipment;
- They are likely to invest much more in medical equipment and devices and also in specialized and experienced medical personnel, thus involving a focus on high-end human resources and high-end technology;
- They tend to have better systems and processes and usage of IT, which creates more efficient and professional work environment;
- They pay higher rates to staff at all levels and particularly to senior medical personnel;

- They are more likely to attract overseas doctors and specialists than other hospitals;
- They are more likely to be accredited domestically and/or internationally;
- Their costs are likely to be comparable to or slightly higher than those of non foreign funded large hospitals;
- Their costs will tend to be higher than for small and medium size nursing homes and hospitals, mainly due to greater capital intensity and focus on quality systems and processes and focus on hygiene;
- There could be positive externalities in other areas, some of which could further drive foreign investment in hospitals;
- They could draw away medical personnel at all levels form other hospitals and could adversely impact the quality of medical manpower available to competing institutions;
- There is likely to be closure of substandard institutions, some consolidation of the hospital segment, and new kinds of arrangements could emerge between larger and smaller players as the healthcare sector evolves;
- There could be greater segmentation between the public and private sector with resource flows towards the latter, greater wage disparity, unless innovative arrangements emerge between the two segments and reforms are undertaken in the public sector hospitals.

While there are clearly concerns about the equity, affordability, and market segmentation implications of growing foreign investor presence in India's hospital segment, it is evident that the root cause lies in structural problems that are already present in the healthcare sector, such as lack of affordable health insurance schemes or inappropriate regulations on medical education providers. Therefore, the benefits of foreign investment in hospitals are likely to outweigh these adverse effects, and **the solution lies in strengthening the public healthcare system, in amending certain regulations that affect all players, and in introducing schemes, which provide affordable access to healthcare for all and not in restricting foreign investment**.

Source: Rupa Chanda (2007).

Mode 4

A number of developed and developing countries resort to mode 4 imports to remedy shortages in key health personnel. From the importer's perspective, this reduces the cost of medical education and training, allows greater flexibility in the management of health personnel, and provides access to top-quality personnel trained in specialties that are sometime not available locally. In turn, this contributes to facilitating technology and knowledge transfers.

The flexibility of mode 4 also allows some countries to remedy health care provider shortages in remote or underserviced areas (see e.g. Canada). In many countries, the attribution of visas to health personnel is subject to economic need tests.

- **Risks associated with increased trade / aversion to opening**

Domestic health markets are highly regulated and often characterized by a high level of protection against imports. Motives underlying some level of regulation and/or protection may be legitimate, although a number of measures allow mitigating the risks and maximizing the benefits of opening. Here again, a distinction should be made according to the mode of service supply, and to whether the service is provided/consumed domestically or abroad.

Mode 1

So far, trade in health services under mode 1 has remained limited mostly due to technological reasons. With the current level of technological development, mode 1 does not appear cost efficient. For other services ancillary to health, such as back office or transcription services, the argument may not prevail; however, these activities could be a challenge for regulators, e.g. with regard securing confidentiality of medical information.

In general, mode 1 imports could fall in the cracks of domestic regulation. How to ensure that a doctor operating abroad meets all the qualification criteria required or respects applicable deontological rules? Mode 1 trade in health services could increase the risks of malpractice, unless an adequate regulatory framework is put in place.

Mode 2

Mode 2 – and trade in general – should not become a substitute for domestic reforms. In the case of Oman (case-study n°1), government-sponsored medical travel is supplemented by domestic reforms aimed at limiting imports under mode 2: between 1990 and 2006, the number of Omani seeking treatment abroad has been halved; investment in an oncology center made the number of patients seeking such treatment abroad drop by 92 percent. In Abu Dhabi, government-funded medical travel for cardiology decreased by 55 percent from 2004 to 2006 after a cardiac-surgery team with significant international experience set up shop in the Emirate (Ehrbeck, Cuevara, and Mango, 2008). Mode 2 imports are only a second best and should remain a temporary solution awaiting domestic capacity building.[3]

Mode 2 presents similar regulatory challenges as mode 1. How to control the quality of the services provided abroad? Who should bear the costs of follow-up operations in case of medical complications (many insurances refuse reimbursement of such operations)? On what basis should reimbursement be done? Answers to these questions have important ramifications: at stake are the equity of access (if, absent an adequate sponsoring/insurance scheme, only the rich can afford to seek treatment abroad) and the quality of health care. For patients, travel abroad remains suboptimal due to the inconvenience of travel and the desire to undergo medical procedures in a familiar environment.

It should be noted also that resources spent abroad are diverted from the domestic health system and the dynamic effects are confined abroad. In addition, the unit cost of hospital care highly depends on the volume and overall capacity utilization of a facility; thus, increased imports under mode 2 result in higher treatment costs at home (and, worth case scenario, for those who cannot afford traveling).

Mode 3

The impact of imports under mode 3 will considerably vary according to the nature and the objective of the investment. It is often feared that foreign establishments will only target a foreign traveling clientele or a rich domestic clientele: this again would raise concerns regarding equality of access to health care. Moreover, foreign establishments (supposedly paying higher salaries than the public or domestic private sectors) could divert scarce human resources to treat a fortunate clientele, to the detriment of the poor and the objective of universal access to health. For the government, this internal brain drain is a lots return on public investment on education. This could also add to the initial cost of attracting foreign investors (fiscal incentives, building infrastructures, etc.).

There are, however, a number of measures that a government can take to mitigate these risks. Leakages are higher if the markets are segmented: for example, in Tunisia, offshore clinics benefit from a higher degree of openness to trade (e.g. investment incentives for foreigners,

[3] It remains necessary for government to prioritize their expenses in the health sector; the cost of certain technologies might justify for some countries to continue sending patients abroad instead of diverting resources from other more vital investments.

authorization for foreign doctors to practice) but can treat local patients only within a certain legal limit (20 percent of the clientele). As a result, there are more leakages, and spillover effects for the local population are minimal. On the contrary, in Indonesia, foreign investment is directed to private wings in teaching and tertiary care hospitals in cities other than Jakarta. There, positive spillover effects are maximized. Similarly, in the case of Thailand (case study n°6), the government has introduced compulsory public service and requires from the private sector a contribution to investment in education (to both avoid and compensate for the effects of internal brain drain).[4]

Mode 4

Imports under mode 4, if not properly managed, could raise a number of issues. First, mode 4 movements of personnel are often mistaken with permanent migration. Then, the media has related a number of stories where nurses, and sometimes doctors, from developing countries had been exploited while working on assignments abroad. Foreign temporary employees could be perceived as a threat by national employees if different labor conditions (including salary) apply. This is unfortunately a frequent scenario, and while not a disincentive for mode 4 trade, importing countries should make special effort to avoid such abuses, and better regulate the temporary movement of health personnel.

1.2. The export side: Trade in health services as an engine of growth and diversification

Exports are the focal point of attention of a large segment of the literature on trade. Gains promised to participants to the global race for medical tourism have generated a few vocations. Long neglected, trade in health services appears as a credible engine of export growth and diversification in selected developing countries. While the benefits could be important, it should be noted that not all countries have a comparative advantage in the sector, and some forms of export could have negative effects domestically unless adequate accompanying measures are taken.

- **Global trade and prospects at a glance**

Statistics on trade in services – at large – are scarce and imprecise, in part because services are non-tangible and hence long considered as non-tradable. Health is no exception, and it remains difficult to assess the real size of the global health services trade market. Estimates vary significantly: for example, a 2004 McKinsey study reported that 150,000 foreigners visited India for treatment that year, while a most recent 2008 study by the same consulting firm suggested that "the market is not as large as reported" and placed the current market at 60,000 to 85,000 medical tourists a year (Ehrbeck et al., 2008). Another consulting firm, Deloitte (2008), estimated the world medical tourism market to be around USD 60 billion in 2008 (estimated to grow to USD 100 billion by 2010) and one million+ medical tourists annually, with 750,000 for the US alone (estimated to grow to 6 million by 2010).

Despite these variations, it is widely recognized that trade in the health sector has a strong growth potential. It is also recognized that developing countries will potentially be the main benefactors of these new trade opportunities. Factors of growth include: ageing of the population and growing demand in the North (shortages of health care providers), rising income (and hence demand) and

[4] These measures could also have negative effects, such as increasing absenteeism in the public sector, and should be designed with great care.

emergence of a middle class in the South. These factors, combined with an increasing control of spending in the North, create new trade opportunities, in particular for developing countries. Deloitte (2008) plans on a 100 percent annual growth of outbound medical tourism in the US over the next few years. It remains that a number of obstacles need to be removed, such as the absence of portability of health insurance, for trade to really flourish.

Not all trade modes are equally developed and have similar prospects. A recent ECIPE study suggested that there was a great deal of variation within different segments of international trade in health services. The author suggested (focusing on the European Union) that, for the most part, international trade was conducted through the movement of foreign health professionals between countries (mode 4), as well as the presence of foreign healthcare firms in local markets (mode 3). Trade based on the travel of healthcare consumers to foreign markets remained very low (mode 2), but still significantly higher than international cross-border trade in health services (mode 1) (Herman, 2009).

It should be reminded also that a number of ancillary services and products are traded at the margin of the global health services trade. These include medical education and training, offshore business services, paramedical and wellness, health insurance, pharmaceuticals and medical equipment/supplies, etc. Sometime, health services are also commingled with other services, such as tourism and travel (see case-study n°3) or real estate (e.g. retirement homes with medical facilities). The global health market is therefore much larger than rough estimates on services suggest.

Case Study n°3:
Travel and Health Industries Commingling – The Case of Thai Airways

A number of travel and leisure companies have invested in the health sector and/or offer their clients packages that include some health care. For example, Thai Airways offers a number of health packages through its Royal Orchid Holidays program. These include:

Package in Bangkok

- Superior Physical-Check-Up at Bangkok Hospital (3 hours)
- Medical Check-Up: Hearth Care Programme at Bangkok Hospital (3-4 hours)
- Premier Healh Examination at Bumrungrad International (3-4 hours)
- Physical Check-Up at Ramkhamhaeng Hospital (3-4 hours)
- The Dental Examination and Cleaning at Bumrungrad International (30 minutes)

Package in Chiang Mai

- Physical Check-Up at Chiang Mai Ram Hospital (3-4 hours)
- Check-Up at Rajavej Chiang Mai Hospital (3-4 hours)

Package in Phuket

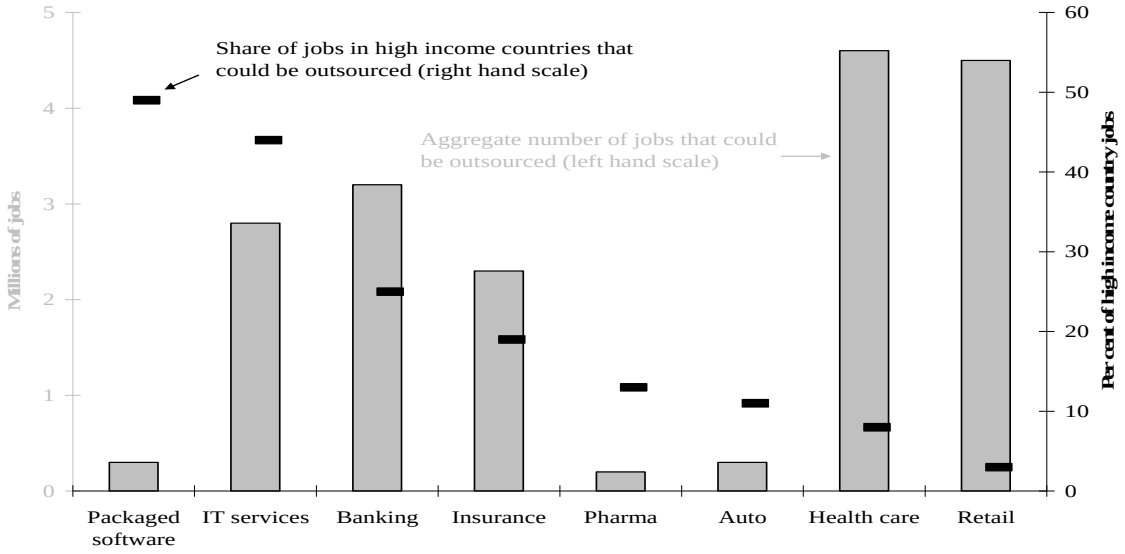
- Medical Check-Up at Bangkok Phuket Hospital (3-4 hours)

Source: www.thaiair.com

Mode 1

As suggested above, trade in health services under mode 1 remains largely anecdotal at this stage, at least if one adopts a narrow definition of health services (for precise definitions, see Nielson, 2006). If one includes off-shoring of other business or financial services, such as medical transcription or health insurance and claims processing, then the market is larger and largely untapped: according to McKinsey (Figure 1) up to 55 percent of these jobs in the high income countries' health sector could be outsourced. Most outsourcing would be done domestically, but some developing countries could capture part of the market. In the case of the Philippines (see case-study n°4), exports of medical transcription services has grown over 100 percent annually for the recent years.

Figure 1: Health is a sector with strong potential for outsourcing



Source: McKinsey Global Institute (2005).

Case Study n°4:
Exports of Off-shore Medical Transcription Services – The Case of the Philippines

The Philippines have benefited from the first wave of off-shoring of medical transcription services (i.e. the process of interpreting/encoding electronically the oral dictation of health professionals regarding patient assessment, therapeutic procedures, diagnosis, and so forth). The first large medical transcription company (Outsource Transcription Philippines Inc.) started in the late 1990's, and benefited from a rapid expansion of medical transcription needs in the US due to changes in health insurance accountancy requirements (1996 Health Insurance Portability and Accountancy Act). The demand for outsourced medical transcription services in the US is growing at 20 percent per year, coupled with a 10 percent decline in the number of transcriptionists in the US each year. The US therefore remains the main driver of trade in this field.

The Philippines comparative advantage in this area is mainly explained by its pool of English-speaking workers (third largest English speaking nation in the world with a 94 percent literacy rate). Transcriptionists are usually medical school college graduates who work part time while preparing for the Philippines' Board exams. The country also has a strategic location, with 12 hour time difference with the US. In addition, the government provides strong incentives for foreign investment in the sector, and supported the industry by implementing key regulations (e.g. on e-commerce and data protection) and developing the IT infrastructure.

As a result, medical transcription outsourcing has grown at a 130 percent rate between 2001 and 2004 – by far the fastest growing outsourcing sector in the country. The majority of the 25 companies exporting these services in 2004 were owned by US investors, and should benefit from an acceleration of the outsourcing phenomenon. In 2004, USD 13 billion were spent on medical transcription in the US, with only USD 2.3 billion on outsourcing. In absolute value, Philippines' exports still represent less than 1 percent of the market, and the growth potential remains substantial. Recent projections suggest that the Philippines will continue to be among the largest markets for medical transcription outsourcing over the next 5-7 years, and could contribute to filling the 47 percent supply gap in the US transcription market.

Source: Blouin et al. (2007); Arunanundchai and Fink (2007).

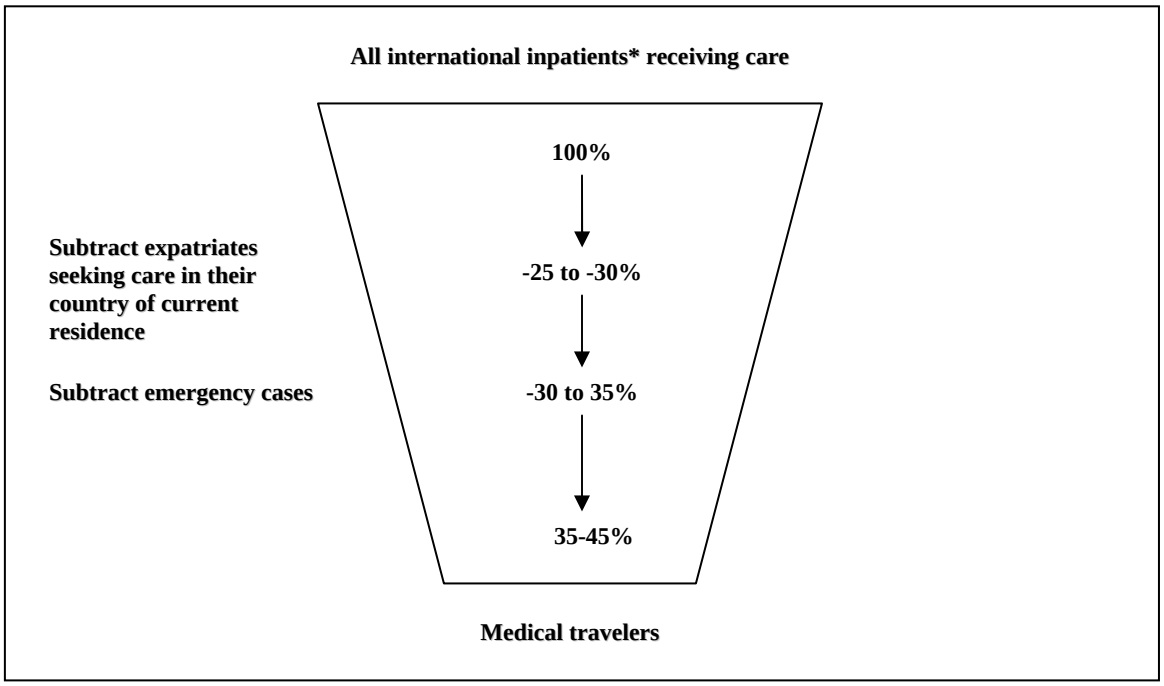
Mode 2

As suggested above, estimates of the number of patients traveling to seek care abroad significantly vary from one source to another. According to some WHO official, this number could reach 4 million patients a year, with over one million for Thailand alone (India, Singapore

and Malaysia due to reach this level by 2012), and an estimated global market of USD 20 to 40 billion (to reach over 100 billion by 2012) (Drager and Smith, 2009).

But is it all trade? As illustrated in Figure 2, McKinsey adopted a narrow definition of medical travel, to exclude expatriates seeking care in their country of residence (25 to 30 percent of all patients treated abroad) and travelers seeking emergency cares (30 to 35 percent); in total, medical travelers would represent only 35 to 45 percent of all patients treated abroad.

Figure 2: A definition of medical travel

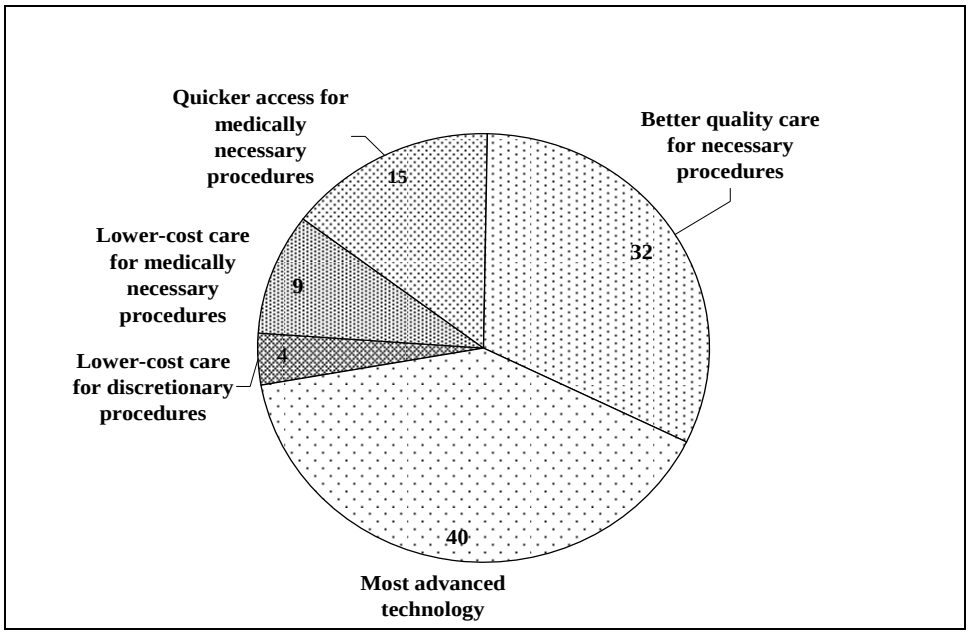


* Outpatients are excluded from analysis because providers don't collect detailed outpatient data; a few providers, however, have substantial numbers of international outpatients.
Source: Ehrbert et al. (2008).

An important question, beyond statistics, is the rationale of medical tourism. Why do patients seek treatment abroad? According to the same study by McKinsey, the main drivers of medical travel are as follows (Figure 3):

- most advanced technology;
- better quality care for medically necessary procedures;
- quicker access for medically necessary procedures;
- lower cost care for medically necessary procedures; and
- lower cost care for discretionary procedures.

Figure 3: Motivation for medical travel



Note: 100% = 49,980 patients (number of patients comes from providers that participated in research; total market size assumes that participating providers represent 60-80% of market)
Source: Ehrbert et al. (2008).

In other terms, the main driver of trade in health services is quality, not price. This suggests that high income countries will remain popular destinations for medical tourists (and therefore exporters of health services), and low and middle income countries with less sophisticated health systems will remain importers of health services under mode 2. It also suggests that there is significant room for South-South trade and a potential high return on qualitative investments made in the health sector in the South. Finally, it shows that North-South trade is confined to a small portion of the market (quicker access and lower cost drive less than 30 percent of trade) and probably does not deserve the excessive attention it has received so far – at least under the current conditions (and in particular with regard portability of health insurance, keeping in mind that the US is by far the largest consumer of health services in the world, followed by the European Union).

These statistics and conclusions seem to be correlated by empirical observations. In the case of ASEAN (case-study n°5), which hosts the top medical tourism destinations in the world, about 70 percent of exports are regional, i.e. South-South (with the exception of Thailand that seems to attract Japanese clients), and probably driven by access to better quality care and more advanced technologies.

Case Study n°5:
Exports under Mode 2 – The Case of ASEAN

	Export revenues	Number of patients	Origin of patients
Malaysia (2003)	RM 150 million (USD 40 million)	More than 100,000	60% from Indonesia, 10% from other ASEAN
Singapore (2002)	USD 420 million	210,000	45% from Indonesia, 20% from Malaysia, 3% from other ASEAN
Thailand	THB 20 million in 2003 (USD 482 million)	470,000 in 2001, 630,000 in 2002, 974,000 in 2003	42% from Far East (mostly Japan), 7% from ASEAN

Three of the top six medical tourism destinations in the world are in the ASEAN region. As illustrated in the table above, Thailand, Singapore and Malaysia have become major exporters of healthcare, servicing both developing countries in the ASEAN region and developed countries such as Japan.

The competitiveness of these three countries primarily stems from two factors. First, due to lower labor costs, they can offer medical services at significantly lower price than their industrial countries competitors (see table above on world price comparisons – one third or half of the price). Ancillary services are also much cheaper: a hospital bed in the US is almost 25 times more expensive than in Thailand. Second, hospitals in those countries have established a reputation for high quality services. In Thailand, service quality has been explicitly promoted by an accreditation system administered by a dedicated government agency – the Institute of Hospital Quality Improvement and Accreditation. The top-rated establishments of the country usually treat foreign patients; they also happen to offer specialized services not available in other, especially poorer, ASEAN countries.

Source: Arunanundchai and Fink (2007).

It remains that some developing countries might want to target niche markets, and continue to tap into the North-South trade potential. For these countries, the two main drivers of trade will be a quicker access and lower costs. Malta, for instance, specializes in the provision of healthcare services for which the waiting list is longest in the United Kingdom, such as hip or knee replacements (Table 2). The cost-driven market is limited by the absence of portability of health insurance that confines the market to discretionary procedures, such as plastic surgery, or creates an important threshold (the comparative price is not the price of the intervention, but the cost to the patient after reimbursement). A number of countries have therefore packaged their medical services with other services, such as tourism, so that the cost becomes only part of the equation. It should be noted that this niche market strategy could pay in the medium-long run, given the forecasted increasing needs in the North, and the necessity for high income countries to contain their health expenses and make their health insurance schemes sustainable.

Table 2: Comparative costs of surgical procedures

	Costs in USD				Costs compared to the USA		
	USA	Singapore	Thailand	India	Singapore	Thailand	India
Heart bypass	130000	18500	11000	10000	14.2%	8.5%	7.7%
Heart valve replacement	160000	12500	10000	9000	7.8%	6.3%	5.6%
Angioplasty	57000	13000	13000	11000	22.8%	22.8%	19.3%
Hip replacement	43000	12000	12000	9000	27.9%	27.9%	20.9%
Hysterectomy	20000	6000	4500	3000	30.0%	22.5%	15.0%
Knee replacement	40000	13000	10000	8500	32.5%	25.0%	21.3%
Spinal fusion	62000	9000	7000	5500	14.5%	11.3%	8.9%

Source: Herman (2009), based on Einhorn (2008) and authors' calculation.

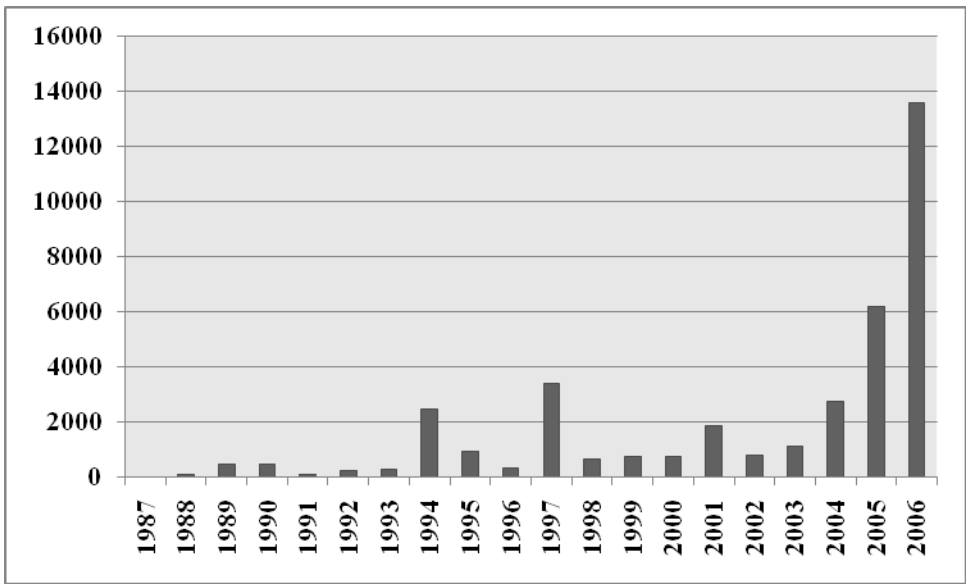
Mode 3

Commercial presence constitutes an important mode of international trade in health services, commonly taking the form of joint ventures between domestic and foreign partners either in equity (e.g. hospital) or non-equity (e.g. management) investments (Drager and Smith, 2009). India (case-study n°2) is a good example of vivid trade under mode 3, with close to a hundred FDI projects in hospitals and diagnostic centers approved during the 2000-2006 period, for a total of USD 53 million, and covering both developed (Australia, UK, US, Canada) and developing countries (UAE, Saudi Arabia, Malaysia, Singapore, Mauritius).

According to UNCTAD, the number of mergers and acquisitions in the health and social services sector has boomed in recent years, to reach about USD 14 billion in 2006 (sales) (Figure 4). Available data does not allow, however, determining the share of developing countries in mode 3

exports. It remains that the largest health services companies have headquarters and operate in high income countries (mainly US, UK, and Canada), and a vast majority of developing countries do not export health services under mode 3.

Figure 4: Mergers and acquisitions in the health and social services sector (sales in USD)



Source: UNCTAD, online FDI database

Mode 4

"Remittances" and "compensation of employees" are the two items of the balance of payments that are commonly used as an estimate of exports under mode 4. Developing countries largely dominate the list of top remittance-receiving countries, with USD 27 billion a year for India, close to 26 billion for China, 25 billion for Mexico, and 17 billion for the Philippines; in total, yearly remittances in the world represent close to USD 300 billion (World Bank, 2008). Remittances have become a major source of income for many developing countries, including for those exporting health labor. This data only vaguely reflects mode 4 trade, however, since one cannot distinguish between remittances of permanent v. temporary migrants, or between remittances of workers in the service v. other sectors. As a result, measuring exports under mode 4 in one specific sector, such as health, is strictly impossible, and no satisfactory proxy exists.

Despite this lack of reliable data, one could assume that mode 4, along with fast-growing mode 2, is a main channel of developing countries' exports in the health sector. Some countries, like the Philippines, have specialized in training nurses "for export". Increasing health personnel shortages in high income countries also guarantees that this segment of the market will continue growing at a fast pace. In 2004, the UK reported that close to 10 percent of its healthcare labor force was staffed with foreign nationals (and 18 percent of its doctors) – number that must have increased since; the Netherlands reported that close to 14 percent of its healthcare labor workforce were foreign nationals (Herman, 2009). On average, 10 percent of the African-trained physicians now reside in the US or Canada – up to 43 percent for Liberia and 30 percent for Ghana (Table 3). In the case of Tunisia (case-study n°6), nurses represent the bulk of the expatriate healthcare workforce, and percentages are much lower: this suggests that healthcare personnel movement is primarily driven by financial incentives and the absence of opportunities at home (the lower the domestic income and the less opportunities at home, like in Sub-Saharan

Africa, the more movement). This also suggests that, given wealth differentials among developing countries, there is a considerable potential for South-South trade under mode 4: in the case of Tunisia, Saudi Arabia is by far the main destination of the moving healthcare labor workforce, and the Gulf captures more than 80 percent of total flows.

Table 3: African physicians practicing in the US and Canada

Country of origin	Number of African-trained physicians in USA	Number of African-trained physicians in Canada	Number of physicians remaining in home country	% of total African-trained now in USA or Canada
Nigeria	2158	123	22894	9
South Africa	1943	1845	23844	14
Ghana	478	37	1210	30
Ethiopia	257	9	1564	15
Uganda	133	42	722	20
Kenya	93	19	4001	3
Zimbabwe	75	26	1694	6
Zambia	67	7	676	10
Liberia	47	8	72	43
Other 12 countries	83	35	12912	1
Total/Average	**5334**	**2151**	**69589**	**10**

Source: www.human-resources-health.com

Case study n°6
Exports under Mode 4 – The Case of Tunisia (year 2004)

	Physicians	Technicians	Nurses	Total	Percent
Saudi Arabia	65	336	827	1,228	53%
Qatar	6	229	130	365	16%
UAE	9	107	163	279	12%
Kuwait	-	1	55	56	2%
Europe	1	2	278	281	12%
Others	21	18	81	120	4%
Total	102	693	1,534	2,329	100%
Number remaining at home	13,330	10,799	28,537	52,666	

Source: Achouri and Achour (2005), based on Tunisian Agency of Technical Cooperation.

Here again, one should interpret these numbers with caution, since mode 4 covers only the temporary movement of persons, and in many cases the intent (with or without success) of the migrant it to permanently stay in the host country.

- **The expected benefits from health services exports**

For all four modes of delivery, exports generate income that benefits the domestic economy and contributes to improving the balance of payments. The dynamic effects of this income will then vary depending on the mode of services delivery.

Exports under mode 1 increase the revenues of domestic health services providers, allow further investment, and potentially improve their profitability, competitiveness (e.g. through economies of scale), etc. They also create opportunities for healthcare providers at home (e.g. work on new technologies) and help preventing international brain drain.

Exports under mode 2 have similar effects. As previously observed (see potential risks of imports under mode 3 above), spill-over effects will depend on the legal/regulatory framework and

business model adopted by the exporting country: these effects will be maximized if the local population can benefit from the infrastructure and treatments developed for foreign patients, or if part of the benefits made by local health services providers are re-injected (i.e. invested) in the domestic health system. The example of Morocco illustrates the different channels dynamic effects of mode 2 exports can take: the high concentration of tourists resulted in an increased supply of health services (available to both foreigners and locals), and the opening of residences for retirees (that provide medical services) somewhat changed local attitude toward elders. The necessity to conform to international standards to export also creates local emulation. Doctors, nurses, and other healthcare personnel are offered greater opportunities at home, and mode 2 exports create a disincentive to expatriation. In sum, a properly designed strategy to export health services under mode 2 has the potential of improving access to better quality healthcare services for the local population.

Exports under mode 3 are returns on investment that are pretty similar to those in any other sector.

Exports under mode 4 could be an important source of income (see e.g. remittances of Filipino nurses). This income would directly benefit the local population (recipients of the remittances), and hence public health. Benefits for the exporting country's health system are indirect only: temporary movement abroad provides the local healthcare providers with a number of opportunities, including access to training, new technologies, acquisition of additional skills and specialization, etc. Upon return to their origin country, those healthcare services providers will make the local population (and their local colleagues) benefit from those skills acquired abroad. Given the fast evolution of medicine, these movements across-borders are particularly important to the sector.

- **Potential risks associated with health services exports and measures to mitigate them**

The risks associated with exports in health services largely mirror those described above for imports, and therefore can be quickly reviewed.

For modes 1 and 2, the main risk is the diversion of scarce human and financial resources to healthcare services entirely dedicated to the treatment of foreign patients. The case of Thailand (case-study n°6) reveals that an additional 100,000 foreign patients seeking medical treatment in the country could lead to an internal brain drain of 240-700 doctors. Exports of health services therefore represent a challenge for the objectives of universal access and equity of access to quality health services. The internal brain drain also represents a loss of public investment in medical education and training. Potentially, the richest local clientele is also diverted to these high-end healthcare services providers to the detriment of the profitability/sustainability of the public health sector. As suggested above and in the case of Thailand, however, a number of accompanying policies could help minimizing these diversion risks, including through the cross-fertilization of public and private health initiatives.

The risks associated with exports under mode 4 primarily depend on the intentions of the migrant. While brain-circulation should be encouraged – and mode 4, as a regulated scheme of temporary movement of personnel, is a factor of brain-circulation – brain drain could have dramatic effects on the local public health. Opportunities for individuals can translate into losses for societies. This is particularly true in the health sector, where the medical density dramatically varies across countries and, within countries, across regions. If anything, a well-regulated trade under mode 4 should contribute to preventing brain drain (agreements on mode 4 can include a return scheme), since nothing can prevent people from leaving a country. Some countries, like the Philippines,

have introduced special curricula and created private schools for training nurses desiring to move abroad. The benefit of such scheme is to limit the government losses (in terms of education) and avoid poaching into the local supply of healthcare providers (since the two training curricula are separate). Some foreign governments have also offered to sponsor some of these dedicated schools in developing countries, which would contribute to reduce even further the risks of public resources' leakages. In the case of South Africa (case-study n°9), some private health services providers have concluded agreements with foreign healthcare networks to provide short-term opportunities for their staff abroad, while controlling returns (this personnel is prohibited from working in the UK system for two years after the completion of their temporary assignment within the UK branch of the South-African group).

Case Study n°7
Mitigating distributive and other adverse effects of trade in health services – The Case of Thailand

The combination of a rapidly rising domestic demand for healthcare, a rapid increase in medical tourism, and a publicly subsidized medical education system that supplies health professionals to both the public and private sectors, presented a formidable policy challenge for policymakers. Thailand's experience with 'flanking policies' aimed at mitigating distributive and other adverse impacts of mode 2 trade in health services provides an important set of possible options for policymakers in countries looking to promote medical tourism to draw upon.

The problems:
In Thailand, private hospitals that treat foreign patients do not participate in social health insurance schemes. Foreigners and upper-income Thai pay out of pocket or are covered by private health insurance. This diverts medical personnel away from public hospitals that serve Thai patients only; many of which participate in the social health insurance schemes. By one estimate, an extra 100,000 patients seeking medical treatment in Thailand leads to an internal brain drain of 240-700 doctors (Fink, 2007; Pannarunothai and Sunak, 2004). A related concern is that tertiary medical education is provided almost exclusively by the public sector, thus private exporting hospitals hire from the same resource pool as public hospitals but do not share the costs of medical education.

The solutions:
Thailand has long enforced a three-year compulsory public service for medical graduates. Two-third of these graduates work in rural areas. Financial incentives for rural doctors include hardship allowance, no-private-practice allowance, overtime and special service allowances. After implementation of the universal coverage in 2001, financial incentives were announced in 2004-05, as a result of which a new medical graduate in the most remote rural district can earn a salary equal to that of a senior doctor in the central department with 25 years of experience. In 2004, the government approved the "One District, One Doctor Project", under which new medical students are recruited from high schools in rural districts, educated in a local university and local hospital, and retained to work in their own districts. These measures are aimed at curbing urban concentration of medical professionals – an important concern in Thailand. In mid-2004, the government also approved a project to rapidly increase the acceptance of medical graduates during 2005-14. The first batch of these graduates is expected in 2011. This highlights the need for a long term and pro-active approach to human resource planning in the health sector, where the duration of education is long. Finally, awards and high-level career classifications encourage rural service and counter internal brain drain.

These measures on the supply side are supplemented by measures on the demand side, e.g. health promotion campaigns, that are expected to curb the domestic population's need for heavy healthcare – as opposed to preventive care.

Source: Blouin et al. (2007).

2. WHAT CAN BE DONE TO FOSTER TRADE IN HEALTH SERVICES?

Increasing trade in health services could be beneficial to both importing and exporting countries, in the high-income as well as in the poorest developing countries. A number of conditions are attached to success, however: the market is very competitive, and not all countries have a comparative advantage in health services; countries interested in entering and contesting the market need to carefully assess their resources and design trade promotion strategies that have both domestic and international dimensions.

The previous section reviewed the potential benefits and risks of trade opening from a public health perspective, suggesting accompanying measures to make the most of trade. This section consists of a check-list of questions/measures to be raised/adopted by governments to design effective trade strategies in the health sector.

2.1. Assessing and fixing the fundamentals, including the regulation of the health sector

Trade does not take place in a vacuum. The same way trade alone is not enough to fix a country's health system, a country cannot pretend contesting the international health services market if its domestic health system is dysfunctional. A country cannot suddenly decide to export health services the same way it could with other basic goods, such as asparagus or fresh-cut flowers, if only due to the high-level of human expertise and technology required. There are some basic prerequisites for trade in health services, and a number of elements have been identified that make a country attractive e.g. for medical tourists or foreign investors.

- **Country endowments: strengths and weaknesses**

With a view to determine whether a country could pretend entering and contesting the world health services market, a common first step is the assessment of the country's strengths and weaknesses – and eventually the design of policies to best exploit the strengths and remedy the weaknesses. The so-called SWOT analysis (strengths, weaknesses, opportunities, and threats) is a diagnostic and planning tool commonly used in the private sector that could also be used as a logical framework for our purposes.

The example of a SWOT analysis for Morocco (case-study n°7) reveals the country's current competitive advantages and shortages in the health sector. It includes an analysis of strengths and weaknesses (SW), which include: price competitiveness, availability, quality and reputation of the health personnel (both doctors and nurses), geographical and cultural (including language) factors, respect of international management or hygiene standards (e.g. ISO-certified clinics), tradition of exports, organization of the sector (public v. private, critical size of clinics), etc.

In a second step, the analysis focuses on opportunities and threats, i.e. external factors affecting the future of the market. From a trade perspective, this analysis is important because countries want to diversify in sectors where international demand is growing and not declining. Also, the parallel reading of "strengths" and "opportunities" helps finding the trade "niches" on which countries could concentrate their efforts. Among identified opportunities, in the Maghreb region, stood: the ageing of the European population (and parallel increase in demand for cares, retirement facilities, accompaniment personnel), the health supply shortages in Europe and in neighboring developing countries (waiting lists for certain operations, skill shortages in Africa), the boom of cosmetic surgery, thalassotherapy and health tourism at large, the gaps in the European health insurance mechanisms (and deterioration of the level of reimbursement, in particular dentistry), etc. Identified trade "niches" included: the dental and prosthesis market, the French-speaking comfort surgery and wellness market, retirement residential programs, etc.

Not all strengths and weaknesses have the same weight when it comes to triggering trade. As previously mentioned, quality remains the main driver of trade in the health sector: entry cost on the health services market is therefore very high in terms of education, training, and equipment. Some countries, like Morocco, benefit from a traditionally well-trained medical personnel – one cannot acquire a qualified labor force overnight, and even less a reputation overnight. Some countries therefore resort to foreign labor in the short-run to supplement their own domestic

resources: in Malaysia, for example, the government has increased the allowed stay under a medical visa from 30 days to 6 months. It should be added that good doctors are not enough, if clinics/hospitals are not properly managed, or if nurses and other paramedical personnel are not properly trained or qualified. Required investments in infrastructure and technology are also important: in Taiwan, the government has announced a USD 318 million project to help further develop the country's health services. Also, the absence of a world database on the safety and quality of care has increased the importance of international voluntary standards: the Joint International Commission (JIC) accredited over 120 hospitals worldwide, and several other organizations, such as the International Society for Quality in Health Care (ISQUA), the National Committee for Quality Assurance (NCQA), the International Organization for Standardization (ISO), and the European Society for Quality in Healthcare (ESQH), have taken steps to ensure that medical travelers receive the highest-quality cares (Deloitte, 2008).

Case-study n°7
SWOT Analysis, health services trade, Morocco

Strengths - Lower cost of services compared to Europe. - Cultural heritage, diversity of the landscapes and tourist attractions, climate. - Geographical and cultural, including language, proximity with Europe. - Facility of access to property and resulting strong foreign presence in residential areas (retirees and temporary residents). - Qualification and reputation of the doctors or hospitals, gained through training or exchanges with foreign universities and medical institutions, and participation to networks with hospitals and research centers abroad (in particular in France).	***Weaknesses*** - No statistics and sectoral strategy at the government level. - Only individual initiatives and difficulty to finance large scale projects. - Skill shortages: Insufficient number of doctors and key health personnel (absolute terms), and lower density of health personnel than Tunisia, Egypt, Libya, and Algeria (relative terms). - Qualification of nurses and other medical staff. - Late in the race with Tunisia and other competitors. - Non application of international standards and certifications (e.g. ISO). - Absence of a clear legal framework for medical tourism that could result in malpractice with an important reputation risk. - Strict nationality requirements that exclude foreigners to practice (and invest).
Opportunities - Booming market of seniors and retirees (ageing of the population): residential programs, medical accompaniment in Morocco and abroad, paramedical services. - Booming market of cosmetic surgery, thalassotherapy and other forms of health tourism at large. - Booming market of dental surgery and prosthesis. - Specialization in some advanced surgical procedures to treat patients in the region: cardiology, cancer treatment, epidemiology, etc. - Expected shortages of certain medical personnel in Europe. - Off-shoring of certain medical services – use of the existing infrastructure. - Deterioration of the level of reimbursement of treatments in Europe and development of the portability of health insurance. - Increasing need for medical training in the region: Mauritania, Mali.	***Threats*** - Protectionist reaction of European countries and ban of medical tourism. - Competition of emerging countries in Asia, Eastern and Central Europe, and the region. - Loss of human resources through the permanent establishment abroad of key health personnel.

- **Improving domestic regulation and removing unnecessary obstacles to trade**

A strict regulation of the health sector is needed, e.g. to avoid malpractice, or encourage the choice of the most efficient providers. At the same time, most obstacles to trade in health services – and services at large – are found in domestic regulations ("behind the border" obstacles). A necessary step for countries aiming to enter and contest the world health services market is therefore to initiate a regulatory audit, which objective will be to ensure that the measures in place (1) contribute to achieving some legitimate policy objectives, and (2) are the least trade restrictive to efficiently achieve these objectives.

The World Bank, the OECD, and the Australian Productivity Commission, among others, have developed trade restrictiveness indexes that aim to identify common barriers to trade in services, including in the health sector. While not addressing the question of the adequateness of the domestic rules (and proportionality to the legitimate objective to be achieved), these help identify possible red flags for foreign investors and best practices. In the case of Tunisia (case-study n°8), for instance, all types of restrictions usually tested are present in the domestic regulatory framework: this would suggest that the government will need to re-assess all these rules in light of both its domestic public health and foreign trade objectives. These include rules pertaining to the form of establishment, foreign investment, nationality and residency requirements, movement of health personnel, etc.

Case-study n°8
Regulatory audit for health services in Tunisia

Type of restriction	**Medical**
Form of establishment	Clinic, hospital, individual practice
Foreign partnership/association/joint venture	Authorized, restrictions apply
Investment and ownership by foreign professionals	Authorized, restrictions apply
Investment and ownership by non-professional investors	Authorized, restrictions apply
Nationality/citizenship requirements	Must be Tunisian
Residency and local presence	No
Quotas/economic needs tests on the number of professionals and firms	Numerus clausus, e.g. pharmacy/ inhabitants
Licensing and accreditation of foreign professionals	Possible recognition of foreign diplomas
Licensing and accreditation of domestic professionals	Inscription on the Tableau de l'Ordre des médecins
Movement of people	Usual visa conditions, exceptional authorizations to practice (e.g. training)
Activities reserved by law to the profession	Yes, practice of medicine
Multidisciplinary practices	Authorized, restrictions apply
Advertising, marketing and solicitation	Prohibited for doctors, authorized for clinics with restrictions
Fee setting	Yes, distinction between public and private

Note: This list is by no means exhaustive: it gives an idea of potential regulatory obstacles to trade. It also does not address the question of the adequateness of the domestic regulations: some are fully justified to ensure the quality of the service, but some might be more restrictive than necessary to achieve this end.
Source: World Bank staff compilation of laws and regulations, restriction index based on Nguyen-Hong (2000).

It appears often that facilitating trade is not about deregulating, but rather better regulating, and sometime even filling regulatory gaps. For example, the deontology in medical tourism is often a grey area with regard domestic regulations. It includes issues such as: the advertising of medical services, the role of tour operators and other intermediaries between the patient and the doctor which might affect the quality of the advice re- the decision to have surgery or the privacy of medical files, etc. Without creating unnecessary obstacles to trade, a deontology code or a set of rules might be necessary to prevent fraud and deceptive practices, not only for the sake of the

patients, but also for the domestic health services sector as a whole, since reputational risks are particularly high in the health sector.

The difficulty of this regulatory review/reform exercise should not be underestimated. First, some regulations that apply to the health sector are not sector-specific (e.g. some rules on foreign investment or visa approvals) – a health sectoral strategy therefore requires cooperation among ministries/agencies. Second, not all rules are set by the government: in many professions, including the medical profession, the professional orders or associations can have important delegations of public authority and regulate the profession (e.g. for the recognition of the qualifications or the admission to practice) – a health sectoral strategy therefore also requires cooperation between the government and the private sector/professional associations.

2.2. Promoting exports

In a highly competitive global market, it is not enough to fix the fundamentals, including the regulatory framework, to suddenly become an exporter of health services. Like in any other sectors, a trade promotion strategy is necessary to gain market shares abroad. The elaboration of this strategy is foremost the responsibility of the private sector (or health services providers at large), but the government also has a major role to play.

- **Business strategies: "niches" and markets to prospect**

The description of the drivers of trade in health services under mode 2 suggests that not all markets are contestable, and not all business strategies can be successful. For example, targeting the French market for medical treatments that are fully covered by health insurance is useless; on the contrary, targeting the UK market for medical procedures that are not quickly accessible in the UK could be rewarding. The knowledge of foreign markets, including healthcare needs (age structure of the population), medical supply (medical personnel density and shortages, in particular by medical specialties), and health insurance coverage gaps, is essential to the design of efficient export promotion strategies. The US is – and will long remain – the world largest consumer of health services, and therefore a main target for health services exports. The increasing demand for health services in high income countries and parallel increasing shortages in healthcare supply could have major effects on trade opportunities: not only those so far net exporting countries could become major importers of health services, but they could become short of resources to supply those developing countries that were importing their services. Thus, there would be room for the most advanced developing countries to contest market shares in the North and in the South.

A good knowledge of the global supply, i.e. competition, is also required. Innovation, like for trade in goods, is important for success: it could take the form of developing new technologies and medical procedures, or packaging the health services differently (e.g. offer of health tourism packages, airport pickup services, translation services, facilitated billing, etc.).

There are a number of success stories that should be looked at carefully by new entrants. The cases of South Africa and Cuba (case-studies n°9 and 10) illustrate successful export promotion strategies under mode 3 (establishment abroad) and mode 2 (health tourism).

Case-study n°9:
Seizing opportunities in the UK, the case of South-Africa

South African hospital companies have been successful in winning healthcare contracts abroad, and particularly with the UK National Health Service (NHS). Netcare established in the UK in 2001. The group's early project was to take part in helping to reduce waiting lists in selected areas: surgical centers in Greater Manchester and Stracathro cumulated 8,000 procedures in the past year; cataract centers delivered 20,000 procedures to date; walk-in centers so far treated 30,000 patients. In 2006, Netcare led a consortium that acquired GHG, owner of the largest independent hospital operator BMI Healthcare. This initiative grew the business by 89 percent, transformed Netcare in one of the world's largest healthcare groups (119 hospitals and almost 11,000 beds), and gave Netcar an outstanding platform for enhancing its relationships with the NHS. As part of this contract, Netcare sends teams of medical personnel from South Africa for fixed-term periods to the UK. These personnel are prohibited from employment with the NHS for a period of two years. Netcare has also piloted a project which allows nursing employees to work 4 to 6 weeks at a time in foreign countries. The objective is to expose South African doctors and nurses to opportunities in UK hospitals, and enable them to supplement their income with fixed term contracts abroad. Staff turnover was significantly reduced as a result, and the group could retain skilled staff in South Africa.

South African healthcare groups are also targeting patients in Africa. Netcare has set-up a network of 'referral agents' in a number of African countries to attract patients to the group's hospitals and doctors in South Africa. They also arrange transport, accommodation and recuperative care for these patients. Other competitors have established foreign patient assistance centers in Johannesburg to assist with transport, visas, accommodation and medical treatment for patients and their families. They employ English, Portuguese and French speaking interpreters and clearly target African patients.

Source: www.netcareuk.com

Case-study n°10:
A successful government-led strategy to develop medical tourism – The Case of Cuba

The Cuban government views health export promotion as an important part of its overall economic development strategy. Cuba has long been and remains a popular destination for medical tourism, attracting patients mostly from South America, Europe, North America, and the Caribbean.

A number of specialized clinics in the country provide high quality care at competitive prices, and also function as medical school training centers for nation and foreign students. Early in the process, Cuba's strategy focused on health spas and mineral springs, travelers' medical back-up or emergency care, and supply of specialized medical care not easily available to people from the Caribbean and Latin America. It also aimed at service differentiation, focusing on treatment of certain kinds of skin diseases which are incurable in other countries, and on the development of new procedures and drugs. This trade promotion strategy had underlying objectives: the employment of qualified health service providers, the use of excess capacity to make medical and pharmaceutical products, and the use of trade resources to invest in healthcare infrastructure and the public health system.

Cuba's success in health services trade can be attributed to foresight and long-term planning of the Ministry of Health in collaboration with other institutions in the areas of tourism, migration, commerce and industry. An important factor of this success has been the establishment of a state-run trading company SERVIMED, hosted by the Ministry of Health, which supported the marketing and promotion of Cuban health services overseas. SERVIMED, together with tour operators and travel agents in target markets, prepares health packages that include air travel (Cuba's national airline) for the patient and accompanying persons, companion personnel from the arrival at the airport, 24h assistance, treatment, repatriation, and post-surgery controls. SERVIMED relies on a network of 35 clinics and 42 resorts in Cuba, private clinics overseas, and commercial representation in target markets like Argentina, Brazil, Chile, Mexico, and Venezuela.

Cuba offers free or subsidized care to patients from some countries, essentially in Africa and Latin America. Cuba has also concluded bilateral agreements with social security institutions in several Latin American and Caribbean countries to facilitate trade. In addition, the government has provided for easy payment facilities with credit cards of any convertible currency. Two smaller agencies have also been established in health tourism to provide rehabilitative and convalescent health services through resorts and spas following the SERVIMED model.

Source: Blouin et al. (2007)

- **Reforming the institutional framework to promote trade**

The above example of Cuba shows that a successful export promotion strategy in the health sector is fully compatible with a large state involvement and the preservation of a predominant public health sector. Indeed, experience shows that governments have played an important role in the success of the leading health services exporting countries. Public involvement could be crucial at all stages, from the design to the implementation of export promotion strategies.

A common problem is the absence of statistics on trade in health services that could translate, at the government level, into the absence of coherent sectoral development strategies. For example, with a view to elaborate an export strategy for medical tourism, it would be useful to know the number of medical tourists, the type of procedures offered, the type and level of expenses of patients, etc. Only rough approximations exist in most countries. Some countries have made efforts to remedying this situation and improve their national statistics on trade in health services by, for instance in Morocco, introducing a count of foreign patients treated in local hospitals. The *Manual on Statistics of International Trade in Services* (United Nations, 2002) provides a useful set of guidelines for governments willing to tackle this problem.[5]

Another related common problem is the absence of cooperation among ministries (e.g. health, trade, and tourism) and dialogue among actors. Practically, too many actors are involved in trade in health services that do not necessarily communicate among each other. These include: tour operators, private practitioners, clinics, hospitals, research institutes, ministries, professional bodies or associations, real estate developers, and (foreign/local) investors. Experience shows that the best performing countries on the international trade in health services scene, such as Thailand, have created horizontal administrative structures to coordinate domestic positions and strategies on health tourism (sometime called "medical tourism observatories"). By contrast, the dispersion of actors remains a technical challenge for lagging countries, for example in Maghreb, where export success stories appear to result from individual and uncoordinated initiatives rather than real strategies.

A number of countries have set up trade promotion agencies, primarily to encourage and facilitate exports of domestic goods and services. It is often the case, however, that these agencies focus on exports of traditional goods rather than services – and hence neglect the health services sector. In the case of Cuba (case-study n°10), the creation of a dedicated agency in charge of promoting and marketing Cuban health tourism has proven successful. Such function could be assumed by an already existing trade promotion agency or part of the mandate of the administrative coordination structure – depending on the country's specifics. In any case, marketing and promotion are essential to boost trade in health services, in particular due to the absence of transparent worldwide data on the quality of healthcare and the important role of reputation in consumers' destination choice.

Finally, it should be noted that public (often university) hospitals have played an important role in the development of many countries' reputation in the health sector, and often continue to showcase knowhow and attract foreign patients or health professionals.

[5] The *Manual on Statistics of International Trade in Services* has been developed and published jointly by six organizations (UN, EC, IMF, OECD, UNCTAD, and WTO), managed through the mechanism of an inter-agency task force. The Manual sets out an internationally agreed framework for the compilation and reporting of statistics of international trade in services in a broad sense.

2.3. Using international cooperation (public and private) to promote trade

A number of obstacles to trade in health services are found in domestic regulation, and can be addressed through unilateral domestic reforms. However, partners are needed to trade, and market access can be hindered by other countries' policies. Hence, unilateral reforms can be traded for concessions (market access) from major trading partners. Using the SWOT analysis terminology, a country's opportunities and threats can reflect its offensive and defensive interests (and therefore negotiating positions) in trade negotiations.

For example, the lack of portability of health insurance is the main obstacle to the development of the health tourism market; the interdiction made (e.g. in France) to tour operators to sell health packages, or the limited recognition of medical qualifications are other examples of external obstacles to health trade. The removal of these obstacles to trade can be negotiated in a number of trade forums and implemented through trade agreements that range from bilateral to multilateral trade arrangements. It is the government's responsibility to design an offensive trade agenda and actively use all available instruments to promote its trade interests in the health sector. The private sector also has a major role to play in this process, indirectly, by informing the government's negotiation positions, or directly, e.g. by encouraging exchanges of personnel or mutual recognition of qualifications. Experience shows that pragmatic solutions could be found at all levels of international cooperation.

- **Bilateral and regional initiatives/agreements**

Bilateral and regional agreements are the most common instrument of trade promotion in the health sector. They can be used to remove obstacles to trade and/or harmonize domestic rules across the region (eventually to adopt regional rules). They can have very different shape, content, legal value (binding and non-binding), and involve either or both developed and developing countries. In part, this flexibility is the reason of their success in the health sector where governments have to deal with a number of sensitive issues and fine-tune trade opening with the realization of public health objectives. Examples of state to state agreements (in a broad sense, not limited to trade agreements) include:

- Social security conventions and other agreements pertaining to the insurance coverage of travelling patients: some social security institutions in Latin and Central America have concluded bilateral agreements with Cuba that contain mutually agreed rates for the treatment of their patients in the island; Libya and Algeria, respectively signed protocols with Tunisia and Jordan, for sponsoring the treatment of their patients abroad (explaining the large success of Tunisia on the Libyan market, primarily under mode 2);
- Bilateral labor agreements: for example between Germany and Croatia or Slovenia, between the UK, India, the Philippines, and Spain, or between Norway and the Philippines for the recruitment of nurses;
- Conventions on education and training of medical personnel that encourage the cross-border temporary movement of health personnel;
- Bilateral/Regional free-trade agreements: an increasing number of FTAs cover health services, such as the most recent European Economic Partnership Agreement with the Caribbean region (for examples of health coverage in FTAs, see e.g. Mikic, 2007);
- Bilateral investment treaties: these mushrooming agreements could also be directly relevant to trade in health services under mode 3.

The conclusion of a bilateral or regional trade agreement is not a guarantee of liberalization or deeper market access in partner countries. The flexibility that made the success of these agreements also constitutes their weakness, since a number of exceptions could be carved out in

each sector that potentially nullify or impair the partners' general commitments. The level of implementation of the agreements also significantly varies from case to case. The example of the US-Morocco free-trade agreement below illustrates how health services could be subject to many more exceptions than other services sectors. It is often the case that health is excluded from bilateral or regional negotiations, such as in the Euromed context.

Restrictions on health services trade listed by Morocco in the US-Morocco Free Trade Agreement

Annex I – Existing measures that are not subject to some or all relevant provisions of chapters 10 and 11

Physicians: A foreign physician may engage in the private practice of medicine only if he or she fulfills certain conditions, including the following conditions, which are inconsistent with the obligations listed above:
(a) have permanent residency in Morocco;
(b) have status as the spouse of a Moroccan national or as a national of a State that has entered into an agreement with Morocco authorizing a national of either State to practice medicine in the territory of the other State; and
(c) have government authorization.
Notwithstanding paragraphs (a) and (b), the Ministry of Health may authorize foreign physicians to practice in Morocco for periods not exceeding one month with respect to specialties that do not exist in Morocco.

Establishing clinics or comparable medical facilities: Only physicians who have fulfilled the requirements for practicing medicine in Morocco may establish private clinics and comparable medical facilities, such as birthing centers, water therapy (*thalassotherapie*) centers, medical care centers and other centers providing in-patient care for periods of at least twenty-four hours, kidney dialysis centers, radiotherapy centers, and chemotherapy centers.

Pharmacists: In deciding whether to authorize a foreign national to practice the profession of pharmacist, Morocco may take into account the needs of the sector.

Pharmaceutical firms: The establishment in Morocco of a firm engaged in the manufacture or wholesale distribution of pharmaceutical products is contingent on the requirement that 51 percent of the capital stock be held by pharmacists. A majority of that 51 percent of capital stock (*i.e.*, at least 26 percent of the total capital stock) must be held by persons authorized to practice as pharmacists in Morocco. In an enterprise established in Morocco and engaged in the manufacture or wholesale distribution of pharmaceutical products, the following persons must be pharmacists:
(a) in sole proprietorships, the sole proprietor;
(b) in corporations, the president and one-half plus one of the members of the board of directors;
(c) in limited-liability companies and limited partnerships, all managerial personnel; and
(d) in other types of enterprises, all the principals.

Dental surgeons, midwives, nurses and opticians: In deciding whether to authorize a foreign national to practice the profession of dental surgeon, midwife, nurse, or optician, Morocco may take into account the needs of the sector.

Private biomedical analysis laboratories: A foreign pharmacist, physician, or veterinarian may establish, operate, and manage a private biomedical analysis laboratory only if he or she fulfills certain conditions, including the following conditions, which are inconsistent with the obligations listed above:
(a) have permanent residency in Morocco; and
(b) have status as the spouse of a Moroccan national or as a national of a State that has entered into an agreement with Morocco authorizing a national of either State to establish, operate, or manage private biomedical analysis laboratories in the territory of the other State.

Source: full text of the FTA available at www.moroccousafta.com.

In addition to these state to state agreements, a number of arrangements could be concluded between public and private, or between private institutions, that also facilitate trade. Typically, a number of hospitals (or universities) have concluded twinning agreements with counterparts abroad that include provisions on the exchange of health personnel for training (or education) purposes. Depending on the delegation of public authority they are granted, medical professional associations can also agree on the mutual recognition of diplomas and qualifications with foreign counterparts. Finally, the involvement of private insurance networks in health insurance conventions could help removing the ultimate obstacle to trade in health services: the absence of health insurance portability.

Finally, it should be noted that regional cooperation is a potential solution to some healthcare shortages or a solution to mitigate some of the risks associated with increased trade. For instance, the development of health centers of excellence in Africa could help neighboring countries to share the cost of medical education and infrastructure investment.

- **Multilateral initiatives/agreements**

A vast literature covers the topic of health services, the GATS, and multilateral trade negotiations, and it is not the purpose of this paper to analyze the GATS provisions pertaining to health (see e.g. Blouin et al., 2006, and WHO, 2005). A few remarks are nonetheless useful to debunk the myth of the GATS.

The GATS allows enough flexibility for countries to maintain regulations that are essential to the pursuit of important policy objectives, such as the protection of public health.[6] The main advantage of GATS commitments is to anchor domestic reforms into the international system, and to preserve the government from later pressures of interests groups. It also sends a strong signal to the investors' community as to the government's will to engage into and secure opening and reform of the health services sectors. Multilateral negotiations also adequately supplement regional ones: beside the economies of scale of negotiations, topics that are set aside in regional negotiations can be more easily addressed within the WTO (balance of powers is different due to the larger number of members). On the other hand, agreements are harder to reach: the Doha round has been initiated 8 years ago and little progress has been made on services. The level of commitments in the health sector remains particularly low, with only 39 percent of members with commitments, i.e. the lowest percentage of all sectors (up to 95 percent of the members have commitments in the tourism sector). Similarly, health is dragging in the GATS negotiations, with only five developing countries offering further liberalization of the sector (Sauvé, 2007).

For each country engaged in the GATS negotiations, it is suggested to follow the following steps. A first step would be to make a clear assessment of all rules regulating its health services sector and bind no less than *status quo*. At no cost, this binding of already engaged reforms (*status quo*) could give some bargaining chips to the government and help negotiating further market access with its major partners. A second step would be to clarify existing rules, in order to measure the eventual cost of opening, and elaborate a strategy to best harness the benefits of opening and multilateral concessions. Where no clear rules exist, a country can keep the right to legislate at a later stage, without slowing the liberalization process (sectoral opt out closes). A third step would be to clearly define the country's offensive interests in the negotiations and bargain for some key commitments of major partners: this could pertain to sectoral as well as rules negotiations.

Finally, it should be noted that the GATS is not the only relevant multilateral agreement relevant to trade in health services. In the WTO, other agreements such as the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) – for rules relating to patenting, for example – or the General Agreement on Tariffs and Trade (GATT) – for commitments on non-agricultural market access, for example on medical equipment and supplies – are also relevant (WTO and WHO, 2002). Other international organizations, such as the ISO, also play a fundamental role in setting standards in the health sector that are main drivers of trade in health services. It is therefore important for all countries involved in international trade in health services to actively participate to international rule making, implementation and enforcement.

[6] GATS article VI is dedicated to domestic regulation.

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