

Trade policies and export of health services: a development perspective

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CONTEXT AND CHALLENGES FOR DEVELOPING COUNTRIES IN THE IMPLEMENTATION OF POLICY REFORMS IN THE HEALTH SECTOR

Never before have so many countries at such different levels of development been involved in so much activity aimed at restructuring their national health systems (NHS). There is an overriding motivation: to achieve a productive transformation of the health sector and make it self-sustainable, cost-effective, and efficient, so as to reduce its burden on the State and increase its economic contribution and performance. In this endeavor, national health authorities face a double challenge: to preserve the integrity of the NHS and to provide universal health care to their populations and reconcile economic interests with the social objective of the NHS. Given that access to health care has a crucial impact on all human productivity, the liberalization and opening of this sector should take into account the primary objectives of health and the social implications of economic reforms.

However, in many developing countries, the social context and economic environment in which the productive transformation of the health sector has to be fostered is being crucially affected by the conditions imposed by the International Monetary Fund and the World Bank. The implementation of structural adjustment programs has provoked sharp reductions in public health budgets and a deterioration of the standard of living. In addition, the limited economic resources plus high rates of population growth in many developing countries have also reduced their policy options to restructure health service systems and achieve sustainable development and equitable economic growth. Furthermore, governments must cope with changes in the health sector that are largely a result of the technological revolution: intensive use of capital, trained human resources, and advanced technology. As a result of the above situations and trends, many governments are taking steps to modernize the sector by implementing new service-delivery schemes through the utilization of

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market mechanisms. Along these lines, market factors at the national and international levels should be considered as one of the driving forces behind sustainable development in the health sector (1).

As financial problems become more acute, governments are obliged to seek cost-efficient and cost-effective approaches and innovative policy devices to overcome the shortage of resources, neutralize the financial crisis, and minimize the negative impacts. With that perspective, many options have been explored; for example, the linkage of the health sector with other sectors such as agriculture, education, trade, or the environment. The use of market mechanisms is also gradually replacing public policy interventions. In many countries, the implementation of policy reforms has brought about increased private sector participation as a result of the sale of public health sector enterprises, the creation of new private institutions, and the encouragement of insurance schemes and community financing for health care programs.

International trade in health services is opening many possibilities for increasing the economic contribution of the health sector to the national economy. Governments from both developed and developing countries are exploring different options including the implementation of export strategies for health services and the liberalization of business ownership to maximize their resource endowment and competitive advantages. This endeavor requires facing the challenge of reconciling trade objectives like foreign currency generation with those of granting their populations universal access to quality health care at an affordable cost. However, any attempt to assess whether the

objectives of health and trade are compatible must be considered in the light of three main interim policy objectives of public health: equitable access to health care, quality, and efficient use of resources. *Equitable access* can be defined as “equal utilization of health services for the same need” combined with *vertical equity*, which means that the users contribute according to their economic capacity. *Quality* refers to the standard of health care provided by the system. *Efficiency* is related to the optimum allocation of resources (2).

Achievement of the above objectives is also influenced by the interaction of internal and external factors that configure the trading environment and the development of a market place for international trade in health services. Among the internal factors are the economic policy environment influencing public health sector policy reforms, the domestic market structure of the health sector, the institutional and physical infrastructures, the regulatory framework, and resource endowments including the number of qualified human resources and state-of-the-art health technologies. External factors reflect the impact of the globalization of health markets and the process of liberalization of trade in goods and services, the investment on intellectual property rights at multi-lateral level (within the WTO framework), the establishment of sub-regional, regional, and interregional integration groups, and free trade areas or the like. An optimum combination of the above factors and due respect for the primary objectives of health would generate positive externalities with multiplier and spillover effects that would support the social and economic sustainability of trade in health services from a development perspective.

Globalization, privatization, and improved information technologies are expanding the global markets for services and providing increased business opportunities for suppliers from developing countries. Despite the potential advantage, there are a number of inherent dangers for NHS of developing countries including the brain drain of skilled professionals from the country, the outflow of financial resources with the cross-border movement of patients, and the creation of a two-tier system where higher-quality care would be enjoyed only by wealthier foreign patients (3).

FUNDAMENTAL PRINCIPLES AND RATIONALE OF EXPORT STRATEGIES FOR HEALTH

Any export strategy for the health services must be founded on the principle of recognizing that the primary obligation of governments is to provide universal coverage of health care to their local communities. The development of an export strategy is secondary to this obligation. According to this premise, development of any sustainable export strategy should be conceived as a means of strengthening the NHS through the following opportunities:

- generating fresh financial resources from external demand, to overcome or reduce the fiscal deficit created by the need to grant universal health coverage;
- improving equity, efficiency, and quality standards in the delivery of health care; and
- upgrading the health infrastructure of hospitals and other complementary structures, as well as technologies and skills.

A crucial element of any successful export strategy is to seek the optimal use of forward and backward interlinkages between domestic production and external markets of health care services, in order to foster the development of a competitive supply of health services and a sustainable health sector. The export strategy encompasses the undertaking of market-oriented actions by individual companies, governments, or private sector associations, or all of them together, to capitalize business opportunities and to reach final consumers in target overseas markets. The most important elements of the strategy are: the rationale (aims); the identification of specific services to export and internal and external barriers to overcome or eliminate; the trade policy devices to promote the exportable supply; and the marketing tools and promotional mechanisms to reach the appropriate consumers in foreign markets. Another key element is to be fully aware of the strengths, weaknesses, opportunities, trade barriers, and threats in adopting strategic actions concerning the most important issues to be addressed.

A number of developed and developing countries are implementing strategies to export health services, in some cases at the expense of the national health system, and the local population has suffered instead of benefiting from those exports. Nevertheless, there are situations where the development of the exportable capacity of health services has contributed to economic and human development in the exporting country and has also been beneficial for the importing country. In the latter situation, health-services export strategies have included a clear

definition of objectives or rationale, and an adequate selection and implementation of the means to target specific segments of health-care consumers in specific overseas markets. Kinnon and Orvill, in their pioneering study "A Public Health Perspective," (2) analyze the premises and conditions that governments need to consider to make health trade objectives and resource allocation compatible with the improvement of the population's health status. Ideally, a policy to promote trade in health services should also further public health objectives.

FRAMEWORK AND TRADE POLICY DEVICES TO SUPPORT EXPORT STRATEGIES

The trade policy framework to develop the export of services, including health services,² has to rest upon the basic principles and disciplines provided by the General Agreement on Trade in Services (GATS). The accord defines trade in services (Article I) as the supply of a service through any of four ways: mode 1, cross-border supply; mode 2, consumption abroad; mode 3, commercial presence; and mode 4, the movement of natural persons. It also provides the framework for domestic disciplines and rules compatible with the Agreement (Article VI), and the principles to negotiate specific commitments and exchange concessions by provisions of Article XVI on market access and Article XVII on national treatment. Other important provisions include: Article IV and XIX, which

provide favorable conditions for developing countries to increase their participation in international trade in services, with due respect to their development objectives; Article V on economic integration; Article VII on recognition of qualifications; Article XIII on government procurement; Article XIV on general exceptions, in particular (c) on measures to protect human, animal, or plant life or health; and Article XV that allows flexibility for the use of subsidies by developing countries.

Developing countries have faced considerable barriers in their efforts to transform services into a major export item and factor for development, and to penetrate the services world market. They have found barriers to market access and national treatment (as defined in Article XVI and XVII of the GATS), as well as difficulties in market entry caused by anticompetitive practices, subsidies, and other means. The next round of negotiations on trade in services under the GATS Article XIX, aimed at the further progressive liberalization of trade in services, is scheduled to begin before the end of 1999. It can provide an opportunity for developing countries to address those barriers. The GATS architecture allows developing countries to offer trade liberalization commitments in the health service sector in those segments and modes of supply where access to foreign services and investment is considered to be most likely to have a positive impact on their economy. Considering that during the Uruguay Round only a few countries made

² The background note by the World Trade Organization (WTO) Secretariat on health and social services (unpublished document WTO S/C/W/50) provides a comprehensive analysis on the applicability of the General Agreement on Trade in Services (GATS) to health services. See also the background note by the United Nations Conference on Trade and Development (UNCTAD) Secretariat on International trade in health services: difficulties and opportunities for developing countries. (Unpublished document D/B/Com.1/EM.1/2, April 1997).

commitments—most of them with no policy implications, —it is possible that the future round of negotiations will come closer to exerting pressure for changes in the trade policy regime by seeking a higher degree of openness (4).

The strategy framework for the export of health services encompasses many interrelated elements governing the NHS and the achievement of the primary objectives of public health. It includes three main components:

1. *The regulatory regime* applied to public health institutions and their performance; development and management of the health infrastructure; application and use of health technologies; private operators as natural persons or companies or any other type of legal entity; health business operations including competition rules; and prudential measures to protect the integrity of public health and medical practice.
2. *Trade policy measures and mechanisms* to promote and support the development of health enterprises in the public and the private sectors. They include all types of market incentives such as tax incentives and duty waivers, development programs to strengthen the competitiveness of the small and medium-sized enterprises in health, financial schemes, and grants to create or upgrade supply capacity; and direct subsidies to support the economic performance of health enterprises.
3. *Trade agreements and the like* are also policy instruments of growing importance, as they are being used by countries to enlarge market access and the dismantling of trade barriers; to liberalize health services in the context of multi-

lateral agreements (e.g. within the WTO), economic integration agreements and free trade areas, or any other type of treaty with existing or potential trading partners. It should be mentioned that in addition to the GATS, other instruments such as the multilateral agreements on the Trade-Related Intellectual Property Rights Agreement (TRIPS) and the General Agreement on Tariffs and Trade (GATT) have special relevance to the trade in health services.

Negotiations on the liberalization of trade in services are taking place in different forums and at different levels—bilateral, regional, and multilateral. All negotiations are, however, interrelated, since commitments adopted at one level influence developments in others, making the whole negotiating process rather complex. The higher the level of commitments adopted in the multilateral framework and the wider their scope, the smaller the space left for preferential liberalization to take place in the framework of bilateral or regional agreements. Members of subregional integration agreements, therefore, need to assume a common position as to the sectors in which access to foreign services could have the greatest benefit for their respective economies and development goals. The first priority in a subregional grouping would be to strengthen and harmonize the regulatory structures governing a priority list of services including health services.

New export capacities can be enhanced by preferential access to neighboring developing countries and that access can in turn be augmented by cultural and linguistic factors. Support for the natural tendency to

export to other countries in the same region may be provided, for instance, by removing visa requirements and limitations on the movement of natural persons; by establishing common curricula among the members of the regional grouping, which would greatly facilitate the mutual recognition of diplomas and other professional qualifications; by easing the requirements for obtaining the necessary permits and authorizations for foreign firms to conduct various aspects of their operations in the host country; and by opening up public procurement to firms from other countries of the region.

FOCUS OF THE STRATEGY

The strategy should be focused on mechanisms and policy devices to support the supply of health services in all or any of the four main modes of international trade in services. Market opportunities rest upon product and services differentiation, which will vary depending on the market targeted and the mode of supply.

The adoption of a strategy to export health services normally brings about the establishment of supply and demand-driven supporting mechanisms to stimulate the exportable supply and the implementation of institutional arrangements and facilities in and out of the country, in support of the marketing of services in foreign markets. A key element in many successful export experiences has been the ability of firms and of the private and public sector associations to understand market requirements and respond accordingly.

Different market and service segments will require different strategies depending on factors like the

market demand and size, the presence of other competitors, and the competitiveness of the product. Countries that represent potential markets have specific requirements in terms of both the types of services they are looking for and the type of exporter with which they will do business. To develop marketing approaches, the health industry must be aware of these requirements. The exporters also need to recognize and understand the differences between markets both within and across countries, and be able to identify niches. The focus of the strategy is highly dependent on the structure of the national health system and the mode of supply in services dealt with.

MARKET OPPORTUNITIES AND BARRIERS

The demand for cost-effective health care solutions is growing as delivery costs spiral upwards, consumer expectations of specialist care rise, and populations age (with the attendant chronic health conditions). In many countries, the government role as a health care provider is decreasing, with a resulting growth in private health care. Opportunities for developing countries exist through all four modes of supply, provided that barriers such as the following can be managed: perceived quality of health professionals available and standards of quality assurance in health care facilities; mutual recognition of professional credentials; nonportability of insurance coverage; lack of standards for electronic medical records; concerns about patient privacy and confidentiality in distance health care delivery; and difficulties in cross-jurisdictional malpractice liability.

The limits to competition presented by equity, social, cultural, and development considerations in many service sectors are clearly illustrated in the health service sector, where lives of individuals are at stake. The benefits that may accrue from the development of trading opportunities (e.g., remittances and temporary movement of health professionals to provide services abroad resulting in upgrading of skills) must be weighed against the potential negative effects such as a brain drain and overspending on state-of-the-art technology for foreigners. As countries explore opportunities for trade in health services, a balance needs to be struck between regulations that promote trade and an appropriate regulatory framework that supports universal service provision and national health policies of equity and sustainability (2).

Cross-Border supply

In cross-border supply (telemedicine), skilled health professionals in developing countries have the potential to provide consultation from a distance now that medical images, X-rays, MRIs, and other techniques can be digitized and transmitted via computer. Other distance-delivery options include training and ongoing professional development for health care professionals, especially backup for health care workers in more remote communities, development and maintenance of interactive on-line health education databases, and remote medical records management.

Consumption abroad

With regard to consumption abroad, a number of developing countries are targeting “health tourism.” Experience has shown that patients will travel

abroad for specialized treatment involving advanced technology or particular medical approaches (such as traditional Chinese medicine), convalescent care, and lower cost quality outpatient care. In the health services sector, the nonportability of health insurance is the major difficulty hampering developing country delivery of health services to foreign patients. This situation is reflected in the commitments scheduled by Bulgaria, Poland, and the United States, which explicitly indicate restrictions on the coverage of public insurance schemes outside the country. The same situation occurs, however, in those countries which allow consumption abroad without limitations. The European Union (EU) has dealt with the problem of nonportability of public health care insurance by means of a system under which sickness benefits in kind are provided according to the legislation of the country in which a EU citizen resides or stays, as if he or she were insured in that country. After delivering the service, a bill is submitted to the health insurance of the home country for payment. In some other countries (Costa Rica, Egypt, Jordan), patients can be authorized to obtain treatment abroad at the cost of the NHS when the system is not in a position to provide the required treatment. Some countries have signed bilateral agreements which allow total or partial portability of the public health insurance. A multilateral solution to this problem could be of considerable utility.

Commercial presence

Commercial presence is sought normally through joint or trade ventures and local partnership arrangements so as to have access to certified and adequately trained local

staff. Management contracts and licensing are becoming a preferred means of commercial certifications in hospital services. A significant characteristic of commercial presence in hospital operation is the involvement of management companies whose traditional business is outside the health care services. Hospital management could be an ideal sector for diversification. Another increasing trend is to contract nonhealth-related companies to carry out ancillary services. An additional technique for penetrating foreign markets is through “managed care” services, which combine management and insurance (5). This indicates the blurring that has occurred between many service sectors as a result of information technology and new business techniques. Such a system integrates in varying degrees the financing and delivery of medical care through contracts with selected physicians and hospitals, and links with insurance companies to provide health care services.

The liberalization of trade in services, notably through GATS mode 3, commercial presence, can make a major contribution to the achievement of developmental and social goals. However, certain prerequisites usually must be met for liberalization to have a positive impact. For example, it has been clearly shown that liberalization of the financial services sector should be preceded by the implementation of sound prudential legislation. In the health sector, the presence of foreign suppliers can strengthen or weaken the health care system depending on the structure of the domestic sector.

Movement of natural persons

Developing countries are estimated to supply 56 % of all migrating physicians (2). While demand is presently satisfied

primarily through the temporary migration of skilled professionals as individuals to markets where there is a shortage, future growth will probably occur through the temporary travel of employees of health care firms in developing countries. Examples of opportunities include on-site training and upgrading of professionals’ skills; consultation with health authorities (e.g., regarding AIDS prevention); nursing care for the elderly and the handicapped or for patients suffering from drug or alcohol addictions; and medical services in remote areas, provision of disaster relief or battlefield medical services through contracts with inter-governmental organizations such as the Red Cross or the United Nations.

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

TYPES OF STRATEGIES

Mainly, the following situations are possible: 1. *Strategies implemented by governments.* That is the case when there is no participation at all of the private sector because health care is provided free, and exclusively by the government in public health institutions. Only state-owned companies import or export services in all four modalities of trade in services. 2. *Association between public sector institutions and private sector*

associations. This happens in countries where the public sector is the major player in the rendering of health care within the NHS but coexists with other private sector providers within the social security schemes and programs. This is the case of some countries such as the United Kingdom, Australia, and Jordan. 3. *Strategies implemented by private sector associations*. 4. *Strategies by individual companies*. There are some contrasting differences between these two.

Strategies implemented by governments through state-owned or public companies

The rationale of this strategy is to obtain foreign currency from exports of health services in order to strengthen the financial capacity of public health institutions and make the health sector a contributor to the development of the country. Three examples are Cuba, Jordan, and the United Kingdom.

The case of Cuba

Since the end of the 1980 decade, one of the main objectives of the Cuban government has been to convert the country into a “world medical power.” With this perspective, a multifaceted strategy was implemented, targeting three main market segments; namely, the treatment of foreign patients; the training of foreign students (mode 2, consumption abroad); and sending medical personnel abroad (mode 4, movement of natural persons), especially to countries with a serious shortage of health workers.³ The strategy for treating patients rests

upon the development of a supply of high-quality health care at competitive prices in specialized clinics headed by eminent Cuban doctors of outstanding reputation. These clinics also function as medical school training centers for national and foreign students. The Hospital Hermanos Almejeiras, specialized in neurological surgeries, bone marrow transplantation, and neurological recovery, and the Clinic Cira García specialized in retinopathy and ophthalmology are two examples among the 35 specialty clinics in Cuba. These treatments are also associated with the development of new drugs.

The trading company SERVIMED was created to support the marketing and promotion of Cuban health services overseas. SERVIMED, together with tour operators and travel agencies from main markets, prepares health packages of available treatments in Cuba. The package includes travel in Cuba’s national airline and other travel facilities for the patient and accompanying persons, if needed, 24 hours assistance, companion personnel from the arrival of the patient in Cuba, repatriation, and post-surgery controls. More recently, the Cuban export strategy is linking health care with tourism and offering new services to healthy travelers and senior tourists. SERVIMED and other Cuban trading companies are developing new concepts of business ventures with other firms (mainly hotels) as part of the “health tourism” strategy and building medical resorts and villages conceived as “off -shore medical centers,” where a great diversity of services is offered, such as beauty

³ During the last decade, Cuba has sent its surplus medical personnel including junior physicians, nurses, and paramedical professionals to South Africa, Italy, Spain, and Portugal. Also in the framework of international cooperation agreements with countries in Africa and Latin America, more than 30,000 medical personnel participated in solidarity missions.

treatments, antistress programs, and convalescence after surgery in a specialty clinic. For an efficient support to marketing, SERVIMED has opened commercial representations in target markets like Argentina, Brazil, Chile, Mexico, and Venezuela. Furthermore, to meet the increasing demand from Brazil, SERVIMED opened a Cuban hospital there, in association with Brazilian investors, for the treatment of skin disorders.

The Cuban strategy's success is shown by the increasing numbers of patients that travel to that island every year. During the 1997-1999 period, more than 30,000 patients and 2,000 students went to Cuba for treatment and training, respectively. Income earned from the sale of health services to foreigners amounted to more than US\$ 30 million. Cuban success in implementing the strategy described has been the result of planning foresight under the leadership of the Ministry of Health and the collaboration and coordination of other public institutions in the areas of tourism, migration, and commerce and industry.

The case of a national health system overseas enterprise

This situation occurs when the public sector is the cornerstone or a very important player in the implementation of a strategy to export health care services to foreign markets from public enterprises. The United Kingdom and, to some extent, Australia are the most relevant examples.

In 1988, the United Kingdom created the National Health System Overseas Enterprise (NHSOE) as the marketing arm of public health companies and institutions to export the existing skills and personnel from

the public sector to other countries. The strategy had a twofold purpose. First, it sought to strengthen the financial capacity of public health institutions to maintain and increase public health coverage and standards, by exporting medical services and thus counterbalancing the trend toward decreasing contributions by the government. Second, it aimed at providing development and career opportunities for British staff in the NHS through their participation in overseas projects. The NHSOE has full autonomy from the NHS in defining the marketing strategies and means of market penetration.

The NHSOE strategy is oriented in two complementary directions: one seeks to offer the whole wide range of services available in the public health sector and, the other, to find business opportunities by bidding in international tendering to implement health projects with multilateral agency funding. The first perspective focuses on four areas: (1) education and training programs for foreign students in public universities and public hospitals; (2) health services consulting; (3) procurement and supplies; and (4) development of health care buildings. Under the second perspective, the NHSOE is very actively participating in international tendering for project development in the health programs developed by multilateral funds and agencies in developing countries. The NHSOE is a registered consulting firm with the Overseas Development Administration, the World Bank, The European Commission, The African and Asian development Banks and the Inter-American Development Bank. The NHSOE often enters into associations, creating temporary consortia with private firms in the UK on an ad-hoc basis, to provide jointly the full package of

services in multilaterally funded projects, when the public sector cannot provide it alone.

The target markets for the above projects are the Commonwealth countries, the Middle East, the Far East, and Asia, including Singapore, Thailand, Malaysia, Indonesia, and China. The NHSOE has implemented projects in more than 50 countries in different regions of the world. One of its main promotional tools is to organize study tours in the UK for health care professionals in any area of interest for overseas visitors interested in either upgrading their skills or developing commercial contacts. To this end, the NHSOE maintains a comprehensive computerized register of professionals from all disciplines in the health care field and also has close working links with many British companies, which offer complementary services while also enjoying special relationships with teaching institutions including a consortium of universities and the Royal College of General Practitioners. Through these associations, the NHSOE can offer customers a complete package of services matching their requirements.

Another complementary aspect of the strategy involves public hospitals of the NHS. It consists of reserving a limited number of private beds to meet the demand of nationals covered by private insurance schemes and foreign patients paying on their own or through British insurance companies that do business overseas.

The impact of this strategy has been very positive. Through the NHSOE, public health institutions have been able to sell services overseas by pooling their surpluses of highly skilled human resources, medical technological advances, and idle

capacity of the existing health infrastructure, thus obtaining fresh financial resources that match the shortages in the allocation from the national budget. In addition, through training and educational programs, the NHS has to a certain extent overcome the shortage of medical personnel (mainly, of specialized nurses and paramedical personnel) within the public sector by encouraging foreign medical professionals to fill salaried training posts and supernumerary posts in public hospitals, for limited periods of time.

Jordan has made great strides since the beginning of the 1990s toward becoming the medical center of the Arab world. In this context, it has launched massive investment programs to upgrade and modernize public hospitals and medical schools. It has, at the same time, created incentives for national and foreign private investment in the health sector. As a result of this strategy, 11 new private hospitals have started operations; most of them have state-of-the-art technology, including computerized links with prestigious health centers in Europe and North America.

Joint strategies implemented by the public and private sectors

The National Health Industry Development Forum (HIDF), Australia

In Australia, about 75 % of the capacity of the health care industry is in the NHS, which is the cornerstone of the social security systems in the Commonwealth. Since the 1960s, the NHS has been experiencing a deep

transformation to provide full health care coverage to citizens. As a result of that process, the health care industry has reached maturity and sophistication, and has earned a worldwide reputation. The Australian NHS is implementing an export strategy to capitalize competitive advantages such as its high standard of quality, excellent infrastructure, and technological expertise in preventive and curative medicine. By means of this strategy, the Australian Government aims at making the NHS a contributor to its own development, by bringing fresh financial resources from overseas sales. In that context, during the mid-1980s, many public health care institutions in different States started to develop schemes of cooperation and trade mainly with countries in the Western Pacific Regions. Nevertheless, the implementation of export capacity is considered a secondary aspect, while recognizing that the primary goal of governments is to ensure full health care coverage of their domestic populations.

The first step in this direction was the establishment of the National Health Industry Development Forum (HIDF) in Australia in 1994, a collective effort to develop a common approach focused on a commercial vision in various parts of the health industry. The Forum is jointly convened by the Commonwealth ministries for Industry and Health, through their respective departments, with the support of the Australian Trade Commission, Austrade. The strategy framework to support the export of health services encompasses a nationwide program to develop the manufacturing and services industries, where health services benefit from twenty different mechanisms of assistance to enterprises including technical advice, training, financial incentives, grants,

and promotional mechanisms and marketing tools to penetrate foreign markets.

The aim of the Forum is to foster the development of a broader and deeper export industry based on:

- encouraging cooperative group action and networking to identify the impediments to industry development, and taking action to remove them; and
- providing industry outlooks to the government and involving the industry in strategy development and implementation processes; then monitoring progress and coordinating activities.

Despite the HIDF being a nationwide initiative, decentralization of the NHS allows effective implementation of the strategy undertaken by each State, with full autonomy from the central government. All public health institutions belonging to States of the Commonwealth are directly engaged in the exporting of health services. Victoria and New South Wales are the most important Australian states exporting health services overseas. The implementation of health export strategies in New South Wales and Victoria are supported by the Forum with participation of both private and public sector institutions. In the state of Victoria, the government created the Overseas Project Corporation of Victoria (OPCV) to strengthen ties with other nations and to offer a focus for the provision of both Victorian and Australian public sector expertise in international development projects. Similarly, in New South Wales, since 1996 Australia Health International (AHI) is the government's central agency promoting the export of services. In both states, public sector corporations and private sector

institutions, including the Chamber of Commerce, form a group of enterprises and individual companies under the umbrella of the HIDF and work together in the implementation of the strategy and overseas promotion inside target markets. An important development stemming from the overseas strategy has been the creation of sister structures similar to the Forum, which promote mutual benefits in the health care business by targeting such markets as Indonesia, Malaysia, and Vietnam.

In both Australian states, strategies are focusing on the four GATS-defined modes of international trade in services:

Cross-border trade (telemedicine)

By promoting and supporting research and development in the application of multimedia processes to the delivery of health care and taking advantage of a well-developed infrastructure and the low cost of telecommunications, Australia aims at becoming an eminent telemedicine center. Australian use of telemedicine ranges from the treatment of primary health care patients, hospital management, and support of national health campaigns to prevent contagious diseases in some Asian countries, to the treatment of patients at the tertiary level in most medical specialties and surgery. Furthermore, video-teleconference facilities are also applied to long-distance medical-training programs encompassing schools in Sidney and Melbourne and universities in Indonesia, Malaysia, and Singapore.

One of the main elements of the strategy to promote cross-border trade is the development of networks and networking facilities between Australian

health centers—medical schools, universities, and public health institutions—and similar establishments in the Western Pacific Region, mainly in Indonesia, Malaysia, and Singapore as target markets. Another important component is the joint research and exchange program carried out with outstanding USA and UK universities involved in advanced telemedicine developments. The purpose is to upgrade national capacities and skills related to human resources, as well as to overcome barriers to trade in telemedicine such as quality standards, accessibility, and compatibility of medical infrastructures. Implementation of this strategy shows that the development of telemedicine can reduce the possible overcrowding effects caused by an excessive demand on the part of consumers from foreign countries.

Consumption abroad

The strategy to promote this mode of trade has two main orientations: the treatment of foreign patients and the training of foreign students. Foreign patients have available a certain number of private beds in public hospitals and an almost limitless supply in private clinics. The rationale for the allocation of private beds in public hospitals is to obtain additional financial resources from overseas patients to reduce the number of Australian patients on the waiting list for specialized treatment. It is argued that with the income earned from treating one foreign patient, two or three Australian patients can be treated as well, depending on the specialty, and deleted from the waiting list. Some private firms have recently invested to increase the number of private beds in public hospitals, in order to improve coverage of both

private and public local demand and the treatment of foreign patients. To facilitate the flow of those patients to public and private clinics, Australia has created a medical visa.

Public medical schools in New South Wales and Victoria are focusing on training foreign medical personnel and students at the undergraduate, graduate, and postgraduate levels and offering special courses in many areas of health. This strategy is meant to create new sources of income to match the trend of decreasing allocations from the national budget in order to upgrade the infrastructure, research, and development, and the living and working conditions of the teaching staff. To satisfy foreign demand to enter Australian medical schools, specialized international departments have been created. Those departments are promoting career opportunities in target markets like Malaysia, Indonesia, Singapore, Hong Kong-China, Thailand, and countries of the Middle East. In very important markets such as Indonesia and Malaysia, one of the most effective promotion methods has been to celebrate a public graduation ceremony with the same protocol and solemnity as in Australia.

Foreign students are also attracted by programs developed jointly by their universities and the most important universities in Malaysia, Singapore, and Indonesia, and by new ones offering joint programs. One advantageous feature of this strategy is that it is less costly for the students, as they can remain in their country for the first three years of their career, while enjoying the same programs and on-line tutorial facilities and teleconferences that eminent professors provide in Australian universities. For the last three years of the curriculum and medical practice,

students are allowed to attend Australian universities. As a result of the above strategies, the income earned from overseas training activities contributes up to 20% of university budgets.

Commercial presence

The development and strengthening presence of commercial Australian health firms in the most important demand-originating overseas markets is one of the main thrusts of the National Health Industry Development Forum. The commercial presence of Australian firms overseas is promoted and supported by the trade intelligence units of Austrade, which have commercial representatives in many countries.

The direct commercial presence of public health companies is limited to the time it takes to implement overseas projects. Very often a consortium of public and private firms is created on a case-by-case basis to implement projects. Moreover, many public and private firms including medical schools are entering into longer term joint ventures. Many private firms are also investing in building private hospitals with partners from other countries.

Movement of natural persons

There is no specific strategy to facilitate the movement of Australian personnel overseas, except when it is linked to commercial presence in any of the situations described above. However, the entrance of certain foreign paramedical personnel and nurses from Commonwealth countries into Australia is facilitated after completing immigration requirements and the recognition of qualifications and licensing procedures.

The Australian strategy described above shows successful focusing by targeting each mode of supply. It also shows the key importance of supporting mechanisms implemented by the private and the public sectors working jointly.

Strategies implemented by associations from the private sector

The case of London Medicine

The best illustrative example of strategies implemented by associations from the private sector is London Medicine, a coalition of health service companies created in 1993 with the funding, sponsorship, and subscription of the London medical and business communities, and the local and national governments. London Medicine seeks to enhance London's leadership in medicine. The primary aim is to increase the flow of clinical, educational, and research work to London's hospitals and medical schools and to attract research contracts and investments from British and international companies. Another important element of the strategy is to ensure that the excellence of London medicine is reflected in London's itself becoming a healthier city.

London Medicine's strategy has two main objectives: to present London's medical excellence to the world and to provide information, guidance, and support to overseas clients. On one side, London Medicine will promote that city as the medical capital of the world and publicize the unique features of its hospitals and medical schools. On the other, London Medicine will be a source of easily accessible information for anyone

interested in London's medical facilities, whether they are students, researchers, patients, practitioners, or business people.

To achieve its objectives, London Medicine has undertaken two lines of action: research and communications. In the first direction, a comprehensive review of London's medical activities has produced an overall picture of the medical facilities and official disincentives that penalized the export of services in relation to goods. Mechanisms used to promote the export of goods have not been available to service producers because services have not been viewed traditionally as an export sector. Service producers suffer from the high levels of tariff protection imposed on imports of capital goods and other inputs required to produce services efficiently. Service exporters often lack access to export credits and are unable to obtain the rebate of indirect taxes on exports permitted to goods exporters. By contrast, some countries such as Colombia have introduced policies to enable service exporters in sectors such as tourism, medical services, and land transport, to benefit from duty drawback on imported goods used to produce exportable services.

Private company strategies

Parkway Health Group (Singapore)

The Parkway Healthcare Group is the largest health-care investment group in Singapore and one of the largest health care organizations in Asia. The Group adopted Gleneagles International as its trade name. A key element in the company's strategy has been the acquisition of hospitals in Singapore,

building up a base and then stepping out into the region in joint ventures with partners in the host countries. Gleneagles has set up joint considers that having local partners in long-term relationships is essential for the strategic direction of the investment. The local contacts and commitment are also crucially important to ensure success. Another key element of the group's strategic direction is the development of a highly integrated network of health companies in the Asian region that can offer patients a wide range of high-quality and cost-effective health care services. The expected results of the strategy have materialized in Singapore, where the three Gleneagles hospitals were the first hospitals in Asia to achieve ISO 9002 international quality certification. In addition, all three hospitals have become regional referral centers for medical care.

The Raffles Medical Group (RMG) in Singapore

Another type of strategy is being implemented by the Raffles Medical Group (RMG), which has a network of 28 hospitals and miniclincs in Singapore. The RMG is looking for strategic alliances overseas by developing triangular business associations with health care organizations from developed countries, to venture into third countries in partnership with host-country investors. An example of this strategy is the Memorandum of Understanding between the RMG and Kaiser Permanente to form 50-50 joint ventures for various health projects in the Asia-Pacific Region. Kaiser Permanente is a nonprofit American health organization considered to be

the world's largest health organization. It has a turnover of more than US\$ 14 billion and covers the health care needs of seven million Americans in 13 states. Kaiser Permanente brings to the joint venture a wealth of experiences in health care: feasibility studies, consulting planning, construction staffing, and management. The RMG contributes its 20 years of experience in building a network of general practice clinics, forward integration into specialist and hospital services, and knowledge of the health care industry in Singapore and other regional markets, particularly in Hong Kong, China, Indonesia, and Malaysia. Negotiations are going on with Malaysia and China on this type of venture.

MERCOSUR

Health cooperatives in the MERCOSUR countries have created the *tarjeta MERCOSUR*, a card that allows patients enrolled in the health cooperative of one country to receive health care in another country through the services of the associate cooperative (6). The main obstacle in implementing plans has been the lack of similarity among the four national health systems of the MERCOSUR countries.

In Canada, some private clinics are interested in exploiting the American market, relying on the high quality of their services and comparatively low prices. A clinic in Toronto is negotiating with United States insurance companies and health maintenance organizations to offer their customers medical services at a fraction of the USA cost. This formula could lead to an unprecedented integration of Canadian and American health care (7).

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