

Trade in health services in the Region of the Americas¹

INTRODUCTION

This working document provides an overview of recent trends and some issues involved in the commercialization of medical and health services in the Region of the Americas. The traditional trade relations between South and North have been shifting rapidly and a far more complex web of alliances is superseding them. The health care “industry” and myriad health-related services are among the sectors where change is occurring most swiftly.

The direct private purchase of specialized medical services abroad always has occurred as a relatively sporadic activity, whose impact on the wealthy consumers’ country was negligible. Today, however, new forces are realigning the form of access to biotechnology, information technology, pharmaceuticals, direct health services, insurance coverage schemes, and the employment opportunities they entail. Among these are:

- health care reform, including the privatization of health care coverage plans;
- the modification or removal of traditional trade barriers resulting from integration schemes and the formation of common markets (Annex A);
- the growth of a large corps of skilled health service personnel in Latin America and the Caribbean;
- the availability of modern, fully equipped hospitals, clinics, and laboratories in the largest urban centers;
- the existence of large national pharmaceutical and medical supply and equipment production capability in several of the large countries;
- improved information technology capability;
- changing demographic patterns;
- signs of significant economic recovery going into the new century;
- increased presence of affiliates of foreign manufacturing and other production firms, and

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- the rapid growth of travel among countries, including the emergence of tourism as a major, non-traditional export item for many countries in the Region.

The juxtaposition of these trends offers growth opportunities for both the private and public sectors in both northern and southern countries. Especially in the latter group, they may help address a significant challenge: how to provide work for the large proportion of the population that is currently un- or underemployed, while retaining the valuable national resource the most skilled among them represent.

As southern countries undertake measures to reform their public sectors, some also have considered increasing their sources of employment (and foreign exchange) by fostering nontraditional exports, including health services. According to the South Centre:

In marked contrast to the general trend in recent decades in favor of liberalization of trade and freedom of capital flows, there has been an overall tightening of restrictions [by northern countries] on international migration. Historically, large scale movements of people from one region to another have played an important role in transmission of growth, . . . relief of destitution, and evening out of income differences. . . . The present patterns of migration are biased in favor of flows of skilled people from the poor to the rich countries.

In coming decades . . . some developing countries with agreeable climates, pleasant environments, and skilled personnel, may wish to specialize in the export of these services [care of the elderly in hospitals or specialized homes] just as many of them do in tourism.

. . . These new opportunities could provide a highly income elastic and lucrative source of profits and employment.

This is, in fact, what has been occurring in the Region. Although privatization of health services and their opening to trade are not necessarily synonymous, the first has accelerated the second in a number of countries. In the southern countries, attempts to promote international trade of health and health-related services are taking place in countries as politically and economically diverse as Brazil, Chile, Costa Rica, and state-run Cuba.

Meanwhile, industries in the Region's northern countries—including those related to pharmaceuticals, health education, information, supplies, equipment, direct services, and insurance—have recognized the same trends and are increasing their presence in newly opened or soon-to-be opened regional markets. From the standpoint of international commerce, in fact, by early 1999 “the scope for foreign investment in the region's health care industry” was so extensive that *The Economist's* Intelligence Unit felt it warranted special coverage. It hence launched the new quarterly *Healthcare Latin America*.

Current discussion of the issues at a regional level is difficult because of the wide array of systems, reforms, and resources that exist. Furthermore, the very nature and relative novelty of the trend and the lack of recognition of its weight in the economy mean that, by definition, systematic data tracking is not yet available. Moreover, many of the data that would need to be tracked to obtain an accurate assessment of the costs and benefits involved are not currently included in

health services trade definitions, or are not desegregated.

Among other things, southern and northern marketing strategies may be distinct, but their execution is not always independent. By way of example, a national clinic or insurance company in the South may export services to its southern neighbors. These services may also constitute a northern country or inter-regional export, due to alliances with companies from the North countries. Tourism statistics often include aggregated data on travel whose real purpose is some form of health or medical treatment at a southern country spa or clinic that is, in turn, partly owned or affiliated to a corporation from abroad. The web of these corporate overlays can be intricate and difficult to disentangle.

These trends are likely to continue well into the next century, and other southern country regions will likely follow suit. Benefits from such arrangements, including employment, training, revenue enhancement, and improved quality of some services, may accrue in southern countries. Nevertheless, as the trends unfold, a number of complex policy issues are emerging for both the health and trade sectors. Many of them overlap. Some may require decisions on the part of national governments and groups of nations that make up subregional trade groups. Others involve the framework and the corresponding data analysis, to inform global trade negotiations and the role of international organizations.

This report briefly summarizes general information culled from secondary sources, cites specific cases for which data exist, and articulates questions that may help frame future policy research and formulation. It

does not cover developments in specific countries, such as Chile and Brazil, for which separate presentations will be given.

THE CHANGING CONTEXT

Medical services always have been the object of international exchange, with the wealthy importing or seeking out the best available physicians, nurses, and pharmaceuticals across state and national lines. Those who could afford to, traveled—even great distances—to renowned medical centers where they could receive treatment or take part in experimental protocols with new pharmaceuticals, surgical techniques, and other medical innovations.

Physicians at specialized centers such as the Baylor, Mayo, and Faber clinics in the United States became the media focus for contemporary instrumentation and pharmaceutical research accomplishments in saving and prolonging lives. Their notoriety marked the public advent of a less publicized new era characterized, among other things, by:

- the emergence of a large corps of highly qualified clinicians, laboratories, and public health personnel in both southern and northern countries;
- the proliferation and greater specialization of state-of-the-art medical centers;
- the specific marketing of specialized units within medical complexes;
- a vast array of new pharmaceutical, diagnostic, and treatment options;
- the greater availability of public information, and

- the increasing willingness, or even eagerness, of insurers to pay for what were once considered special services.

These developments made it possible for many people with ordinary incomes in northern countries to have access to the most advanced treatments available. Global economic trends also mean that, even in those countries where basic public health indicators remain very low, the affluent and middle classes are creating demand for the same services. This demand is in turn reflected in increased trade.²

At the same time that this health care industry was expanding, demographic patterns were undergoing change. Northern countries are now characterized by an aging population, which, as a group, may have access to more disposable income even into its senior years. However, that population will also have a greater need for specialized health services, long-term care facilities, health-friendly retirement environments, ancillary devices, pharmaceuticals, and more frequent interactions with the medical care industry. The corresponding increase in costs is compounded by the rising production costs of health-related research, production, service facilities, and insurance in northern countries, where the proportional size of the work force is declining.

Most Latin American countries, on the other hand, have young populations. During the 1980s and early 1990s, the economic crisis threw

millions of people out of work and severely cut the incomes of others. Regionwide, almost half of the working-age population continues to earn its living in the poorly paid, often hazardous, informal sector. Although the economies of most of the countries are improving, the pool of highly skilled workers who have limited domestic employment opportunities also is sizable. This situation provides an incentive for northern companies to set up production facilities in the South, as well as to enter southern markets with subsidiaries geared toward marketing services to middle and upper income groups. Furthermore, the growing number of northern nationals traveling to and residing in the South create a natural market extension at a lower cost.

In addition to the South-North dynamics, the liberalization and regionalization of trade in the Region have created South-South demographic patterns with significant consequences for the health sector. The increase in labor migration affects skilled and unskilled workers alike as well as their families, the local population, and health services upon which they come to rely. Tourism between countries in the Region also has grown tremendously. Monitoring the potential epidemiologic impact of such movements is a regular cooperative undertaking with a longstanding relationship to trade. Intercountry differences in the availability, cost, and reimbursement of health-related educational, information, and emergency, specialized, and routine

² The General Agreement on Trade in Services (GATS) refers to the general trade in services as taking place in four modes. Mode 1 occurs when a service is provided "from the territory of one Member to the territory of another Member;" Mode 2 occurs when the service is provided "in the territory of one Member to the consumer of services of another Member;" Mode 3 takes place when a service is provided "by a provider from a Member through the commercial presence in the territory of another Member," and Mode 4 applies when a service is provided "by a provider from a Member through the presence of individuals from a Member in the territory of another Member."

clinical services are considerable. Approaches to their standardization and compatibility are still under scrutiny.

CROSS-BORDER WEBS

It is possible to examine international trade in health services from a number of different angles. For the purposes of this study, it may facilitate discussions to group such trade, albeit somewhat fallaciously, according to the point of origin of the service export.

South-to-North export of health services

When unemployment and inflation are low (the case in northern countries for the better part of the 1990s), health care and medical technology consumers may feel that discretionary services, such as cosmetic surgery, some dental work, and stays at spas of various sorts are affordable out-of-pocket expenses. This is especially the case when those services are available more inexpensively than at home, confidential because they remain outside the domestic “tracking” system, and may be purchased along with a vacation. Noninvasive, non-aggressive, or other nontraditional approaches to health maintenance and disease cures are services for which interest and purchases also are on the rise.

Most of these activities involve travel by the northern consumer to the southern (mostly private) provider and at-site, out-of-pocket payment for services. The volume of this sort of nontraditional export in some countries may now qualify it as a significant source of revenue (see Cuba, below). However, just how extensive such trade is in most

countries, to what degree it is part of deliberate trade strategies, how much leakage occurs, and other clear-cut data are difficult to ascertain.

New health insurance alliances and efforts to reach reimbursement agreements for services provided to northern (mainly USA) nationals receiving emergency as well as standard care in Latin America and the Caribbean, indicate that this particular type of trade will increase over the next decade. A related export that some countries are exploring is the establishment of specialized geriatric facilities that include everything from medical care services to healthy lifestyle programs for elderly persons wishing to relocate.

Latin American and Caribbean countries also export services in the form of health-related education, training, and databases. Reliable quantitative reports regarding the volume and value of these export activities are not generally available.

South-to-North trade in services in the Region of the Americas can be grouped roughly according to the four GATS modes of trade in services (Table 1).

North-to-South export of health services

For decades, medical centers in northern industrialized countries have recruited wealthy patients actively from around the world for services ranging from organ transplants, complex neurological surgery, and high-tech fertility treatments, to cosmetic enhancement. Although no reliable data are available for comparison, it is likely that, profitable as these services may be for the institutions involved, they do not

Table 1. South-to-North service exports in the health sector, by mode, Latin America

Service mode	Information / Information technology				Pharmaceutical	Supplies and equipment	Direct services	Insurance coverage
	Education	Data	Tele- medicine	Internet				
Cross-border supply	√	√	∅	√	∅ *	∅ *		∅ *
Consumption abroad	√	?			∅ *		√	∅ *
Commercial presence	∅	?	∅ *		∅ *	∅ *	∅	∅
Presence of natural persons	√	√	∅		∅ *	∅ *	∅	∅ *

√ = Service provided.

* = Not included in the current GATS categories.

∅ = Service not provided.

? = Data unavailable.

attract the trade volume seen in other forms of consumer recruitment. Among these, the following stand out:

- study programs at USA universities (including distance degree programs through the internet);
- computerized database linkages and information retrieval;
- specialized research and diagnostic services;
- telemedicine (including routine home care) and ancillary technology;
- services related to modern (high tech) diagnostic and treatment equipment and supplies;
- services related to pharmaceuticals and pharmaceutical production inputs and technology;
- managed care, insurance, and reinsurance services, and
- consulting services regarding the establishment and maintenance of the above activities, as well as the current interest in emergency

infrastructure, systems, and procedures, database management, and other aspects.

The above categories involve services related to pharmaceuticals and manufactured equipment and supplies. According to the US Department of Commerce, the USA exports of surgical and dental instruments and supplies alone almost doubled between 1991 and 1997, and 20% (US\$ 2,656 million) of the total value was from exports to Latin America. Related services are yet routinely quantified. If it were possible to desegregate them, the extent of health care-related services might be more readily apparent.

The array of services related to health provided North-to-South covers practically every GATS mode (Table 2). The export of medical services by affiliates of USA companies also rose substantially during that period, according to *The Economist*.³ US Department of Commerce figures⁴ indicate that the sale of health services

Table 2. North-to-South service exports in the health sector, by mode, Latin America and the Caribbean

Service mode	Information / Information technology				Pharmaceutical	Supplies and equipment	Directservices	Insurance coverage
	Education	Data	Tele- medicine	Internet				
Cross-border supply	√	√	√	√	√ *	√ *		√ *
Consumption abroad	√	?			√ *		√	√ *
Commercial presence	√	√	√ *		√ *	√ *	√	√
Presence of natural persons	√	√	?	√	√ *	√ *	√	√ *

√ = Service provided.

∅ = Service not provided.

* = Not included in the current GATS categories.

? = Data unavailable.

by USA affiliates of Latin American companies amounted to US\$ 31 million in 1995, and declined to \$21 million in 1996. The balance of the total of \$360 million in such sales in 1996 took place in the United Kingdom and other European countries. By contrast, total expenditure by USA citizens who purchased USA affiliate health services in Latin America and the Caribbean increased eightfold, from less than \$500,000 in 1995, to \$4 million in 1996. Data were not available on the actual number of persons seeking such services.

The special case of insurance and managed care

Hospitals, research laboratories, universities, and pharmaceutical, equipment, and supply firms have

formed, for decades, a sometimes-complex web of international information, referral, and marketing services. The international expansion of insurance providers recently has increased to an extent that has warranted extensive coverage in the press, and one newspaper to dub it the “tropicalization” of such services.

In part, the expansion of the presence of foreign insurance companies is due to business travel and the establishment of affiliates by multinational firms whose employees are accustomed to and demand a certain quality of care when they are treated locally. The trend also is due to direct, aggressive marketing on the part of insurers who find that profit margins in industrialized countries are diminishing while their growth in the South is promising.

³ *The Economist Intelligence Unit. Health care industry. Healthcare Latin America 1999; 3rd quarter: p.35.*

⁴ US Department of Commerce. Tables 9 and 10. *Survey of Current Business 1998.*

According to the president of the American Association of Health Plans, “450 million Latin Americans constitute a health-care market of \$120 billion a year—of which only 15% is spent on private insurance.”⁵ Industrialized country insurance companies moved into Latin America with accelerating momentum during the mid-nineties, as national reform policies opened markets.

Foreign insurers are drawn, among other interests, by the immense funds available in the Region’s social security and pension plan systems. Providing health insurance is also seen by some in the insurance industry as a “necessary evil” that makes it possible to establish the relationships necessary to enter other forms of business. Furthermore, as long as regulation is lax and risk-based premiums and client selection are possible (cherry-picking, or cream-skimming practices), profit margins help offset losses in northern countries.

The heightened activity of insurers is reflected in newspaper and journal articles alike. According to RL Boyle, as early as 1986 a Washington State medical center was positioning itself to market its services in China, Japan, and Korea.⁶ Meanwhile, Latin America has been a “testing ground for reform worldwide.”⁷ Six years later, in 1992, in an article published in the *International Journal of Health Services*, Mexican researchers Laurell and

Ortega expressed concern that the NAFTA agreements could lead to the increased presence of foreign insurance firms and hospital consortia, decapitalize the public sector, and lead to a more acute rift between the public and private health care systems that cover the 20 million plus Mexican market.⁸

Compared to life, property, and casualty insurance, direct provision of health insurance is still considered “too risky . . . due to lack of adequate market and patient information,” declared in 1999 the *The Economist’s* Intelligence Unit. Sources within the insurance industry note that health insurance is also less profitable than other forms of insurance because, unlike life insurance, for instance, customers feel they should get their money’s worth. Furthermore, regulations are not uniform.

Where the managed care market is concerned, *The Economist* noted recently that “no country, apart from Chile, has yet begun to turn to . . . [direct services in the form of foreign managed care programs]. HMOs have still to prove themselves a successful export product.”⁹ Nevertheless, buying stakes in private national insurance and service companies has become a growing business, some of which is taking place South to South as well (Table 3). “The market potential for this kind of product is vast,”¹⁰ states *The Economist* regarding such insurance alliances in the Region.

⁵ Lewis J. The Americas shift toward private health care. *The Economist* 1999; May 8:27-29.

⁶ Boyle RL. Response to a growing international market. *Coll Rev* 1986;3(2):27-38.

⁷ Lewis J. The Americas shift toward private health care. *The Economist* 1999; May 8:27-29.

⁸ Laurell AC, Ortega ME. The Free Trade Agreement and the Mexican health sector. *Intl J Health Serv* 1992;22(2):331-337.

⁹ *The Economist* Intelligence Unit. Health care industry. *Healthcare Latin America* 1999;3rd quarter: p.9.

¹⁰ *Ibid.*, p. 11.

Table 3. South-to-South service exports in the health sector, by mode, in Latin America and the Caribbean

Service mode	Information / Information technology				Pharmaceutical	Supplies and equipment	Direct services	Insurance coverage
	Education	Data	Tele- medicine	Internet				
Cross-Border supply	√	√	√	√	? *	? *		√ *
Consumption abroad	√				√ *		√	? *
Commercial presence			∅ *		√ *	√ *	√	√
Presence of natural persons	√	√	∅		√ *	√ *	√	√ *

√ = Service provided.

∅ = Service not provided.

* = Not covered by current GATS categories.

? = Data unavailable.

South-to-South export of health services

Trade in health services between Latin American and Caribbean countries is also taking place on a larger scale than in the past. Cross-border trade, such as that which occurs between North and South, takes place South-to-South as well, although to a lesser extent. A 1994 report¹¹ found that consumption of health services in neighboring countries (GATS Mode 2: consumption abroad) was increasing, although the difficulties in obtaining insurance reimbursement was cited as a significant barrier to such trade. Mode 3 activities are taking place as well, as can be seen, for example in the Brazilian insurance industry's penetration of Colombia's market, and Chilean company ventures in Mexico.

As shown in Table 3, South-to-South trade in health services takes place in almost every category and

modality. Trade in information (especially in the form of education, training, and consulting services) and direct services have existed for a long time in the Region. Pact negotiations, such as Mercosur's, have been working on establishing common criteria for licensures, accreditation, and related cross-national requirements for integration. Other kinds of health services trade, such as telecommunications-based educational and medical services, and insurance coverage are newer. Many of these ventures are not strictly South-to-South, and do not necessarily emphasize trade within the same bloc. In one way or another, financial and/or industry affiliations exist with firms from northern countries. These range from European, Canadian, and Japanese banks, for instance, to pharmaceutical, insurance, telecommunications, and other information technology companies.

¹¹ Díaz D, Hurtado M. International trade in health services: main issues and opportunities for the countries of Latin America and the Caribbean. Equity and Health Project, Health Policies Program, Pan American Health Organization. Washington, DC, 1994.

It is not the purpose of this paper to cover all of these activities. However, a few specific examples are useful to inform the discussion between the trade and health sectors. The two cases that follow are intended to serve that purpose and provide some insights into further avenues of research and policy formulation. First, the case of Cuba will illustrate a relatively coherent approach to the international provision of health services in all its forms. Second, the trend toward privatization of health coverage in the Region is more advanced in some countries than in others where it is still under review. Nonetheless, most of the countries in the Region are undertaking health-sector reform and some form of privatization is likely in the coming decade. Information on its progress in the countries where it is already in place illustrates some of the complex relationships between privatization and trade.

The special case of Cuba: decades of investments for trade

In Cuba, unlike other Latin American countries, commercialization of health services is a state-run affair. Cuba's medical and health services exports are the product of an explicit national strategy adopted and provided by the public sector. Laws on the books prohibit the sale of medical and public health services for profit. The commercialization of its resources in that sector has not altered the fact that they are free for all citizens. Trade in the sector is run by a special unit of the health ministry (Servimed), whose

mandate is to provide health services to tourists, as well as market them and related products abroad. Cuba's health policy addresses several needs simultaneously, including:

- international solidarity,
- countering the drop in foreign exchange due to the price collapse of its traditional exports,
- compensating for the impact of the USA-led embargo,
- providing useful employment to its sizeable pool of highly skilled clinicians and researchers,
- utilizing its excess capacity in state-of-the-art, Region-appropriate medicine and pharmaceuticals,
- adding value to its burgeoning tourist industry,
- providing an entry point for investment in infrastructure and other areas, and
- securing alternate funding sources for its public sectors.

Cuba's investment in training its personnel and developing the full gamut of necessary services—from clinical, laboratory, and biotechnological to digital imaging—was a sound policy, according to *The Economist*: “Cuba's medical research centers have developed unique products. It should be ideally placed to participate in the international market for medical products and services.”¹²

Cuba was one of the first countries in the Region to begin offering its services abroad. Yet, having begun in 1980, official data available for 1996 indicate that the country's direct medical services export program

¹² *The Economist* Intelligence Unit. Health care industry. *Healthcare Latin America* 1999; 3rd quarter: p.63.

continues to depend mostly on a relatively small number of consumers from Latin America.¹³ Given the economic volatility in the countries of the Region, this could mean that the growth of this industry is uncertain. On the other hand, if the economies of other Latin American countries indeed improve during the next several decades, Cuba may compete successfully with other South-to-South, and North-South-North health services trade.

In 1996, reported revenues stemming from health sector exports were 10% greater than those reported in 1994 (US\$ 21,767 million vs. \$19,424, respectively), and by 1998 they had risen to some \$30 million. The reported number of foreign patient arrivals oscillated, declining by some 10% during the same 1995-1996 period, and rising again in 1998, to some 5,000, according to *The Economist*.

The information available does not elaborate on the extent of foreign investment in Cuba's medical, health services, and spa industry as such. However, of the more than 4,500 foreign companies that have commercial arrangements and investments there, a significant number involve the health sector. Among them, South-to-South joint undertakings exist with companies in Argentina, Brazil, Mexico, and Colombia. Indirect alliances through European, Scandinavian, Canadian, and other non-USA firms, holding companies, and subsidiaries account for another common trade and investment modality. Cuba's export of health services in the form of consulting in biotechnology, pharma-

ceuticals, and informatics spans additional countries in the Region, including the Dominican Republic and Uruguay.

Cuba's tourist trade is the focus of much foreign investment that involves arrangements with countries ranging from those such as neighboring Jamaica, Barbados, and Mexico, to Canada and European nations. Given that Servimed promotes its health services-based "quality of life improvement centers" for tourists, part of the tourist trade involves trade in health services. The same holds true for its line of cosmetic and pharmaceutical exports, and related training and consulting services. Revenues from this export product line doubled between 1995 and 1996, and Cuba has set up clinics and partnerships in several Latin American countries, most notably to extend its renowned treatment for vitiligo.

It is not clear how much the research for and maintenance of these services cost the country. The importation of whatever equipment, supplies, and materials may be required to keep the system functioning at a level that would be attractive to foreigners may reduce profit margins considerably.

Where electronic-mediated services are concerned, Cuba has invested substantially in the infrastructure and technology needed for telemedicine and other informatics. Telecommunications was the largest sector receiving foreign investment during the last decade of the century.¹⁴ Its telemedicine network links hospitals throughout the country, and is used to extend sophisticated diagnostics, surgical, second opinion,

¹³ Gutiérrez García L. *Turismo de salud en Cuba*. La Habana: Asociación Nacional de Economistas de Cuba; 1999.

epidemiologic, and other services to remote areas as well. The year 1999 was the first for Cuba to launch its services across national borders, through the Telemedicine Network (*Proyecto de Telemedicina*) based in one of its major hospitals (Hermanos Almejeiras). In conjunction, the Telemedicine Network and the Medline-like internet-accessible medical and health database service launched in 1992 (InfoMed) place Cuba in the forefront of modern information technology management in the Region.

The sustainability of such an expensive cross-border enterprise depends partly on the same requirements private-to-private enterprises (other South-to-South as well as North-to-South) face: the availability of technologically suited counterparts. Here, too, Cuba has embarked on marketing its expertise in the form of consulting and software services, and hosting conferences on the topic for other countries (recently Costa Rica, for example).

Privatization and trade links: selected examples

The marketing, or commercialization, of health services in other countries of the Region takes place quite differently from the way it does in Cuba, although some trade strategies may be similar. State reforms have gone hand in hand with deregulation, renegotiations of trade terms, and the privatization of health services. Consequently, dynamics are under way that increase the overlap between policies that once applied largely to the national domain

and those that are international. Simultaneously, the universe of services traded in the health sector has expanded considerably: although privatization is not necessarily synonymous with trade, the first often portends the latter.

Chile, for example, established the ISAPRES (*Instituciones de Salud Previsional*, or private health insurers and managed care providers) in 1981 as market-based competitors with the national health insurance program (*Fondo Nacional de Salud*, or FONASA), which was created simultaneously. Enrollment in one or the other is mandatory. Enrollment in the ISAPRES has grown from 62,000 the first year to some 3.8 million in 1998 (around 30% of the population).¹⁵ Some view this as a success, others as a failure of the private sector.

The closely watched competitive system has encountered several difficulties. First, “commercial premiums have been too high to permit widespread adoption of the schemes by the public.”¹⁶ While the ISAPRES cover a good 90% of those with higher incomes, their subscribers account for barely 5% of the elderly. Furthermore, some 24% of those insured by the ISAPRES still use public clinics and hospitals because they cannot afford the copayments.¹⁷ Moreover, the ISAPRES have tended to limit both the menu of services covered as well as the age (including childbearing age for women) and health-risk status of the subscribers they underwrite. That is, those covered have been the most likely not to use the insurance for major

¹⁴ US-Cuba Trade and Economic Council, Inc. Foreign investment and Cuba. New York.

¹⁵ The Americas shift toward private health care. *The Economist* 1999; May 8:27-29.

¹⁶ *The Economist* Intelligence Unit. *Healthcare Latin America* 1999; 2nd quarter.

expenses, and the services offered were selected by expense.

In response to this situation, a law was passed in 1995 requiring the ISAPRES to refrain from “adverse selection against the elderly . . . and [to offer] certain basic services to all” who could afford the premiums.¹⁸ Among other things, Law 19381 introduced measures to increase the transparency of privately-managed care contracts and outlawed the practice of restricting treatment for certain conditions and/or excluding the treatment of preexisting ones.

Half of the closed ISAPRES and a third of the open ones were losing money in 1996, compared to 1995. Foreign firms subsequently took over several of the larger ISAPRES, at least in part.¹⁹ Aetna, for example, now covers some 60,000 of the ISAPRES enrollees through its subsidiaries, and Cigna provides services to another 100,000 in the same fashion.²⁰ Given that there are no restrictions against foreign insurers in Chile, their commercial presence has increased dramatically: by 1996, they controlled 60% of the insurance and reinsurance market.²¹ At the same time, this mixed Chilean insurance industry began to market these services South-to-South in the Region.

Part of those investments are going into foreign prepaid programs. Chile’s Colmena Golden Cross, for example, followed the same strategy as USA-based firms and “bought a stake in a new health insurance unit in Mexico, Plan Salud.”²² To varying degrees, similar patterns of cross-national schemes are occurring throughout the Region. Argentina, Brazil, Colombia, and Mexico are among the most commonly cited countries where this is taking place. Chile’s “market in medical devices and hospital supplies has grown by 39%” in the last decade, and “spending on medical technology in Brazil and Argentina has increased by 20-25%” over the same period.²³ Enrollment in private health plans in Brazil quadrupled between 1988 and 1998. (A separate report in this publication covers developments in Brazil.)

FONASA’s public sector services are comprehensive but deemed to be of inferior quality to those of the ISAPRES. A policy study of the 1983-1999 period is currently under way at the Economic Commission for Latin America and the Caribbean (ECLAC), and preliminary results will be presented at this meeting. For this regional overview, it is worth noting that the researchers found imports of

¹⁷ Stocker K, Waitzin H, Iriart C. The exportation of managed care to Latin America. *New England Journal of Medicine* 1999;340(14):1131-1136.

¹⁸ Ibid.

¹⁹ *The Economist* Intelligence Unit. Financing Foreign Operations. London, 1997. (Report #2501247).

²⁰ Stocker K, et al., op. cit.

²¹ Ibid.

²² *The Economist* Intelligence Unit. Efforts to stabilize Region’s economies. *Crossborder Monitor*, March 12. London, 1997. (Report #2495824).

²³ *The Economist* Intelligence Unit. Latin American health care: guarded condition. *Business Latin America* 1997. London, 1997. (Report #2480253).

medical supplies and equipment were increasing. According to industry information, FONASA has doubled its purchases of technology in the last decade. It is not clear whether the purchases to upgrade the public system represent an additional cost or are in some fashion a benefit from the privatization effort.

In 1993, Colombia also reformed its health system. Its model differs from Chile's, however, in that it specifically legislated measures to increase the access and quality of services for the poor. Private and nonprofit insurers (*empresas promotoras de salud*, or EPS, and *empresas solidarias de salud*, or ESS, respectively) took over the management of health care financing from the Social Security Fund (ICSS) and Health Ministry. These government entities nonetheless regulate payments. Payroll tax contributions are distributed among the insurers according to a progressive formula that attempts to counter risk selection with incentives: lists of enrollees are weighted according to age and gender profiles, and the funds are subsidized accordingly.

Total coverage by this plan grew from 6 million in 1993, to 22 million in 1996, of which the state pays in full the premiums for 7 million poor. Like those in Chile, the Colombian EPS "are launching themselves abroad, marketing their experience of middle income markets," according to *The Economist*.

DISCUSSION AND SELECTED ISSUES

Trade in health services is extensive throughout the American Region. Some of that trade has increased dramatically and it is likely that the trends documented to date represent only a portion of the actual volume.

Some of that trade has followed the privatization of health care services; some has emerged as a demand for technology on the part of both private and public entities increases, and some has arisen out of successful marketing of services on the part of both northern and southern countries to take advantage of trade liberalization policies. Not only has the health-sector trade increased but, considered as a whole, it covers a vast range of services.

Information and information technology

Neither the volume nor the value of services related to information and information technology is well documented. Nonetheless, North-to-South and South-to-South activity in that area is extensive. Education ranges from short-term professional training in the use of disease surveillance methods, laboratory techniques, and software applications, to long-term medical and public health education. Such educational activities take place in all four GATS service modes. Services related to data, in the form of research, analysis, service-system designs (ranging from case-management protocols to outbreak-control procedures and "911" systems), publications, and distribution are also extensive and trade across national boundaries.

The use of the Internet has made some of these services more available and cheaper, while it has spurred the growth of others (such as the international web marketing of clinical services) at a pace so rapid that neither northern nor southern countries have been able to assess the impact. Two million people had access to the Internet (at least for email) in Latin America, and "50,000 firms and

organizations are running 'host' computers for Internet sites," according to one article reporting on telemedicine in the Region.²⁴ USA universities offering professional training have geared up to do so by electronic means. Mexico's FUNSALUD and Cuba's InfoMed are examples of sophisticated southern developments in database construction and analysis, health-information retrieval systems, and consulting services partly intended for trade abroad.

The advent of telemedicine technology and the corresponding image transfer technology could have vast implications for health services, as well applications in other sectors that are not even health-related. In addition to Cuba, mentioned above, a number of other southern countries have been developing the expertise and infrastructure to use telemedicine internally as well as export the service. Argentina, Brazil, Costa Rica, Colombia, Mexico, and Uruguay, for example, all have telemedicine capacity to some extent. In Argentina, where the capacity already exists, telemedicine projects to improve the quality and access to health care in rural areas are now under way.²⁵ In Mexico, six telemedicine and electronic health information projects are in operation.²⁶ Trade in related consulting services between countries is growing.

Topics for discussion

Some of the issues that arise regarding the trade in health services information

and related information technology extend far beyond the scope of the health sector. MERCOSUR negotiations on the use and compatibility of bandwidths, for instance, have begun independently of telemedicine. Regional, national, and international organizations have embraced telemedicine as a means to extend services and reduce costs. While this may be true in the long term, it appears that the momentum toward tele-medicine and other forms of computer-based data trade will increase whether or not their applications enhance equity and distribution. Some of the issues the health sector may wish to consider include:

Costs

- The proportion of the GDP spent on health care (currently around 12.5%) is rising in the Region. The cost of the necessary infrastructure, training, and maintenance of information technology is considerable and could have a medium-term effect of raising rather than lowering costs, especially where public facilities with limited revenue are concerned.
- How can countries take advantage of the potential that technology offers, while ensuring that the costs involved do not add an undue burden to the health care budgets? What measures might be appropriate to prevent the importation of such technology in the private

²⁴ Lifesaving technology: telemedicine technology booms in Latin America. *Medidatos Newsletter* 1997.

²⁵ Sistero RF, Scavuzzo CM, Albornoz CH, Sistero RI, Lamfri MA. A telemedicine program suitable for developing countries. *Telemedicine Today* 1999; 7(4):24-26.

²⁶ *The Economist Intelligence Unit. Science and technology (part II)—telemedicine in Mexico. Healthcare Latin America* 1999; 2nd quarter.

- sector from driving up costs for the entire health sector?
- Can countries that do not currently have significant information technology capability benefit from South-to-South partnerships in its development and trade? Are protective measures required?
 - What is required to ensure self-sustaining telecommunications systems in the health system? How would the private (often partly foreign-owned) and public components of that system share access?
 - Who decides how to categorize health data? How is transnational compatibility established? What are the costs (including the costs in services required to standardize information inputs)?
 - Home care uses and remote location access to telemedical services all require expensive on-site equipment, trained personnel, maintenance, and access to high-speed lines. It has been difficult to execute plans to establish clinics, basic services infrastructure, and other services requiring the presence of skilled professionals and technicians. By what means will these be provided for telecommunications services? How will their reliability, proper usage, and maintenance be ensured?

Equity, ethical, and related regulatory issues

- The use of modern telecommunications technology may both enhance and hamper efforts to

improve the equity of access to health services and the equitable distribution of quality care. Some of the benefits include the possibility of retrieving information rapidly, the “democratization” of access to information by clinicians, researchers, students, and even individual patients. Distance training and education programs could make it possible for health personnel to receive additional training without having to leave their jobs in rural or other areas that are distant from universities. Distance education by electronic means is, according to the US Department of Commerce “the most rapidly growing method of education and training provision in the global economy.”²⁷ Work in classrooms and laboratories could be enhanced by sharing information with others located far away. Patients with chronic diseases could rely on telemedical setups rather than trips to the doctor for routine monitoring. Some issues to be considered are:

- What measures or regulations, if any, might be appropriate to ensure that governments have access to vital information being transmitted to insurers, medical centers, databases, and other endpoints? What are the criteria for data of vital national interest?
- Are there other universal service obligations of telecommunications operators and providers that the health sector considers vital?
- Are reciprocal obligations and standards required where education

²⁷ US Department of Commerce. *Results of the services 2000: a Conference and Dialogue on Global Policy Developments and US Business*. Washington, DC, 1998.

and training services certification is concerned?

- In the case of telemedicine services, how are reimbursements to be covered (still an issue in the USA, for example). Lack of provision for such reimbursement, whether by private, mixed, or public insurers could constitute a restriction of access to all but those who can afford out-of-pocket payments.
- Is the public sector responsible for fallback and/or emergency measures in the event that adverse events interrupt critical distance services?
- Can those countries that have national technological capability develop a formula-based means to channel some of the trade revenues toward an equitable distribution of the benefits? What would the private-public mix in such an endeavor look like? How might the trade component be quantified?
- How should countries address the issues of confidentiality, liability, nondiscriminatory use of the information, and patient autonomy and choice when cross-border services rendered through telecommunications are used?
- What measures are required, if any, to ensure that professional standards and national requirements are met when information, education, laboratory analyses, diagnostic results, and treatment advice cross national borders?
- Have cost studies been conducted regarding the conversion of records and other forms of data not currently computerized? What trade policies would allow countries

who wish to promote this technology and their own industries to do so, while protecting those who are not ready for or have decided not to make the preliminary investments required?

- What trade policies would protect the development of national capabilities in countries where the extent of their endeavors is not yet competitive, without incurring in unfair or counterproductive barriers?
- What are the relative advantages and disadvantages for southern institutions in competing with mixed or northern ones? Should subsidies or other incentives be considered to foster the development of regional cooperative information and information technology dissemination and transfer centers?

Health services

The delivery of effective health services is critical to national development. Moreover, as was recognized in a trade meeting last year, “the ethical and human welfare dimensions make it qualitatively distinct from most other industries and endow it with a high degree of political sensitivity.”²⁸ Nevertheless, trade in health services, be they direct clinical services provided abroad (including due to temporary migration for work reasons), services related to health supplies, medications, vaccines, equipment, or insurance coverage and prepaid plan management, is soaring in the Americas. Fully 20% of USA trade in health takes place in the Region. Trade in insurance coverage and prepaid plan management affects services and commodity trade in the other categories. It may be the fastest

²⁸ Ibid.

growing of the sector services trade and takes place in all four GATS modes.

Topics for discussion

No one will argue that the highly fragmented, inequitable, and inefficient health care system typical of many countries in the Region did not require reform. Attempts to do so have been in the works for decades. How to do it is a matter of national policy. Governments have approached the process in various ways, and many have experimented with privatization schemes. Where this has occurred, privatization has, in turn, led to or increased alliances with companies abroad. Significant trade in coverage services (insurance and reinsurance) is the most notable result.

It appears to be too soon to determine whether reforms involving privatization have improved access, cut costs, and enhanced the quality and equity of care, as was their intent, or are having the opposite effect. It is also difficult to determine whether some expected indirect benefits have occurred, such as increased employment and training opportunities, or the transfer of technology. Some issues concerning trade in these services include:

- Does the trade in private insurance and services provision exacerbate or improve the rift between the wealthy and the poor where availability and quality of care are concerned? Is the change an effect of privatization itself or is it a derivative effect of other economic dynamics taking place?
- What are the relative economic benefits to the country in which foreign-based companies are operating? What is the degree of

leakage?

- What measures may be required, if any, to protect national physicians and other health personnel from undue influences or conflicts of interest when their employers are corporations whose measure of success may not necessarily coincide with national and professional codes of ethics? (The American College of Physicians has dealt extensively with ethical dilemmas created in USA health maintenance organizations, for instance.)
- What provisions should be made for economic downturns or other events that may make it necessary for the persons currently covered by private insurers to avail themselves of public services?
- In the case of alliances with foreign companies, what regulatory measures, if any, should the State impose to ensure that national priorities related to coverage and delivery of health services is observed?
- How should those countries that have a constitutional commitment to universal, means-independent, access to health care deal with foreign nationals who require their services when reciprocal insurance does not exist or the individuals are not covered by insurance?
- What are other health sector implications from trade itself, such as responsibility and reciprocal obligations for the cross-national movement of wastes, hazardous substances, infectious diseases, and chronic diseases?
- Would it be advisable to institute a levy or some other distributive measure to upgrade public services

- and create a “national welfare security” or emergency fund for vulnerable groups or times of economic volatility?
- If private health insurance and prepaid plans depend on foreign capital, what measures are required to ensure that such capital does not suddenly bail out if profit margins are not satisfactory? Is such a contingency a private matter between businesses or should legislation determine the permissible interfirm arrangements?
 - What measures are required to protect citizens and the public health sector from private insurance’s “cherry picking” practices? What can be learned from the experiences of Chile and Colombia in this regard?
 - What can be learned from Cuba’s conscious policy to consider health services a strategic, exportable investment?
 - If insurers tend to “cherry pick” among populations within countries, are they also doing so among countries within subregions? Are trade alliances and reciprocal commitments between countries a useful approach to prevent such distortions, if they exist, and optimize the modernization and equity of health services, especially in countries with small populations and few nontraditional resources?
 - How can southern countries jointly develop their regulatory capacity to deal with trade in health issues?
 - How can the exportable surplus of health care be determined so as to avoid further deficiencies in the coverage of domestic populations?

THE FUTURE: GENERAL REGIONAL TRENDS

The complexity of the issues entailed in trade and health in the Region to some extent involve catching up with events that have been unfolding for more than a decade. Some of the underlying premises on which they are based are changing. A brief summary of two of them—demographic patterns and employment effects of trade liberalization—is in order.

Demographics

While it is now the case that the Region’s population as a whole is young, demographic profiles are already shifting. Over the next twenty years, the bulk of the population will be entering an age group that will need to use health-care services (with a few exceptions, such as those related to reproductive health) more frequently. Current epidemiologic patterns regarding chronic diseases can be expected to rise. The economic implications of this burden could be substantial.

“Creating an economic environment to translate the [age shift] opportunity into higher living standards for its [Latin America and Caribbean] population is a major challenge,” according to recent economic analysis.²⁹ According to that analysis,

²⁹ Behrman J, Duryea S, Székely M, Office of the Chief Economist, Inter-American Development Bank. Aging and economic opportunities: major world regions around the turn of the century. Washington, DC, 1999. (Background paper for the Economic and Social Progress Report 2000: working paper #405).

the age at which public health expenditures rise currently coincides with the age at which unemployment also rises (see Inter-American Development Bank figures).

A number of countries have encountered difficulties in meeting the health care needs of a large portion of their populations while they are still young. It is particularly urgent that national policies be developed to provide for the growth in demand for preventive and curative services that will occur in the near future. The paucity of information to date indicates that systematizing data on the volume, value, benefits, and risks of trade in health services should be an integral part of such policy development.

Effects of trade liberalization

Another recent economic analysis of the Region points to the fact that, as an effect of trade liberalization (the *apertura*), “changes in trade patterns influenced employment and labor remuneration, not via the feared displacements of workers brought about by higher imports. . . . [but in that those imports created a demand which] showed a bias toward skilled labor, and the gaps in remuneration among workers widened. [Furthermore,] trade deficits soared in most Latin American countries.”³⁰ Given the situation, the authors suggest that “the real restriction on economic growth and improvements in distribution is the scarcity of workers who have the higher-level skills.”

This finding has many possible implications for the health sector which are causes for concern as well as optimism. Several that this meeting may wish to consider in its deliberations are noted here. First, should the widening of the remuneration gap continue, it may mean that the (unskilled) proportion of the population that relies on public health systems will increase beyond age-based projections. Second, the scarcity of skilled workers could translate into a more pronounced shortage in the public than the private health sector. This in turn could have an adverse impact on attempts to modernize and increase the equity of health care systems. (Although there is generally no urban shortage of physicians, those who are trained in the use of high technology, for instance, could easily gravitate toward the better paying, more efficiently organized private sector.) Third, whether public, private, or mixed, the health sector in most countries of the Americas has a significant corps of skilled workers, the export of whose services may benefit the economy as a whole. Fourth, given the information presented above, it may be that trade deficits are occurring as a result of health-care sector reform and modernization attempts. Lastly, if some development policies are to be focused on investing in educating skilled workers, the health sector—and its trade—has a lot to contribute to this arena.

³⁰ Lora E, Olivera M, Office of the Chief Economist, Inter-American Development Bank. Macro policy and employment problems in Latin America. Cartagena, 1998. (Working Paper #372).

Annex A. Integration agreements in the Americas

Multilateral agreements	World Trade Organization: General Agreement on Tariffs and Trade (GATT)	
Regional agreements	Latin American Integration Association (LAIA)	
Customs unions	Caribbean Community (CARICOM) Andean Community Central American Common Market (CACM) Southern Common Market (MERCOSUR)	
Free-trade agreements	North American Free Trade Agreement: Canada, United States, and Mexico Group of Three (G3): Colombia, Mexico, and Venezuela Bolivia-Mexico Canada-Chile Central America-Dominican Republic Costa Rica-Mexico Mexico-Nicaragua	
Nonregional temporary preferential agreements	CARICOM-Colombia CARICOM-Venezuela	
Bilateral agreements: Partial scope Economic complementation Free trade and preferential trade Signed by:	Argentina	Dominican Republic Nicaragua
	Bolivia	Ecuador Panama
	Brazil	El Salvador Paraguay
	Chile	Guatemala Peru
	Colombia	Honduras Uruguay
	Costa Rica	Mexico Venezuela
General association and cooperation agreements	Association of Caribbean States Third Declaration of Tuxtla	

Source: Organization of American States, Trade Unit. www.sice.oas.org.

