CPD

Working Paper 96

Liberalising Health Services in South Asia

Implications for Bangladesh

Fahmida Khatun
Mazbahul Golam Ahamad

CENTRE FOR POLICY DIALOGUE (CPD)
BANGLADESH
a civil society think tank

LIBERALISING HEALTH SERVICES IN SOUTH ASIA

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It may be of interest to note that in recognition of the track record in research, dialogue and policy influencing, CPD was selected as one of the awardees under the Think Tank Initiative (TTI) through a globally held competitive selection process. TTI is supported by a number of governments and foundations, and is implemented by the International Development Research Centre (IDRC), Canada.

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The present paper titled **Liberalising Health Services in South Asia: Implications for Bangladesh** has been prepared by *Dr Fahmida Khatun*, Head of Research, CPD and *Mr Mazbahul Golam Ahamad*, Research Associate, CPD. The paper was prepared under the *Liberalization of Health Services under the Proposed SAARC Framework Agreement (SAFAS): Implications for South Asian Countries* project, in collaboration with the South Asia Centre for Policy Studies (SACEPS).

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Acronyms

ANC	Antenatal Care
BDT	Bangladeshi Taka
EPI	Expanded Programme on Immunization
FDI	Foreign Direct Investment
GATS	General Agreement on Trade in Services
GDP	Gross Domestic Product
GoB	Government of Bangladesh
HDI	Human Development Index
ICT	Information and Communication Technology
IMR	Infant Mortality Rate
LDC	Least Developed Country
MMR	Maternity Mortality Ratio
NGO	Non-Government Organisation
PPP	Public-Private Partnership
PPP	Purchasing Power Parity
SAARC	South Asian Association for Regional Cooperation
SAFAS	South Asian Framework Agreement on Services
SAFTA	South Asian Free Trade Area
SATIS	SAARC Agreement on Trade in Services
THE	Total Health Expenditure
UAE	United Arab Emirates
UK	United Kingdom
USA	United States of America
USD	United States Dollar
WHO	World Health Organization
WTO	World Trade Organization

1. INTRODUCTION

South Asian countries have witnessed significant shift in the structure of their economy during the last few decades, in terms of the dominance of the services sector compared to the traditional sectors such as agriculture and industry. The contribution of the services trade in total trade of South Asian countries is increasing over time. Recognising the importance, South Asian countries have embarked on extending regional economic cooperation beyond the free trade agreement on goods (South Asian Free Trade Area (SAFTA)), to services. The draft South Asian Framework Agreement on Services (SAFAS) has been adopted with this end in view. It is expected that intra-regional trade and investment in health services will take place through operationalisation of the SAFAS. This will, in turn, help to improve the quality of healthcare within the region.

Bangladesh, like other South Asian countries, is yet to ensure improved healthcare for all its citizens. Due to inadequate facility and lack of quality services, patients from Bangladesh go abroad regularly. On the other hand, the country also has some corporate hospitals which have the potential to provide high quality healthcare to patients from within and outside the country, particularly from the South Asian region.

The present paper assesses the implications of liberalising health services in Bangladesh under the proposed SAFAS. In doing so, it presents an overview of the health sector and trade in Bangladesh, and identifies the health sub-sectors which can be considered for trade in the South Asian Association for Regional Cooperation (SAARC) region. The paper also explores the challenges and potentials of trade in health services under each Modes of the General Agreement on Trade in Services (GATS) through examining the regulatory frameworks of regional countries which govern their respective health sector. The paper makes a number of policy recommendations for the improvement of health services in the region, and for an integrated health service mechanism under the SAFAS.

The paper is organised in the following manner. After the introductory section, a literature review is presented in Section 2. This section shows the findings of studies carried out in different countries on liberalisation of healthcare services and its impact on their economies and people. Section 3 of the paper provides an overview of the status of healthcare in Bangladesh. The current situation and available opportunities in trade, investment and other potential collaborations in the health sector of Bangladesh are discussed in Section 4. This section also reviews the regulatory frameworks of Bangladesh and other South Asian countries under which trade in health services is governed. This will help to identify the challenges and constraints that affect the prospect of collaboration in the health sector. Finally, Section 5 provides policy recommendations, for improving collaboration between Bangladesh and other South Asian countries in the health sector.

2. LITERATURE REVIEW ON TRADE IN HEALTH SERVICES

Sectors such as health services have traditionally been subjected to strong government involvement since this has been perceived as a major area of responsibility of the state, and also because of the obvious reason of market failure. This, along with some other sectors, such as education, water and sanitation are considered to be basic human rights which a

government is obligated to ensure for its citizens. Therefore, while over 90 per cent of the World Trade Organization (WTO) Members undertook some form of commitment on tourism services, less than 40 per cent made commitments on health. In general, cross-border trade in health services comprises a very small percentage of the total trade in services. Similarly, traded health services are a small fraction of total global health expenditures. However, in some countries, trade in health services has a large share in total trade in services, and the absolute value is substantial and growing rapidly. Some countries have commercial interests in pushing governments to reduce barriers to trade in health services because of the export potentials. On the other hand, some countries feel threatened in opening up their health sectors because of fear of displacement of domestic service providers, and for the perceived risks to the national health system.

Several studies have examined the economic dimensions and distributional aspects of trade in health services (Blouin *et al*. 2005; Chanda 2002; Woodward 2003; Diaz Benavides 2002; Drager and Vieira 2002; Woodward *et al.* 2002; Adlung and Carzaniga 2002; Chanda 2001). Some of the studies explored the barriers of trade in health services and opportunities of liberalising this sector. These studies also discussed the state of affairs and issues such as volume of trade in health, trading partners, commercial presence, movement of personnel, barriers to trade in services, income from trade in services, etc. (Janjaroen and Supakankunti 2002; Gupta *et al*. 1998; Zarrilli 1998; Wasserman and Cornejo 2002; Widiatmoko and Gani 2002; León 2000; Achouri and Achour 2002). Other studies have tried to view it from a regional perspective, especially on specific issues such as commitment to trade, regulation of trade, challenges and benefits of trade within the region and so on (Sabri 2002; Rahman 2000).

The economic impact of trade in health services for developing countries and least developed countries (LDCs) is of importance because of other competing priorities. Blouin *et al.* (2005) listed a number of potential costs and benefits of trade in health services for developing countries which are: foreign exchange earnings and incremental incomes (Mode 2); increase in the range and quality of services available (Mode 2); remittance generated by the temporary movement of nurses, physicians and health professionals (Mode 4).

However, there may be costs associated with trade in health services as follows: resource diversion of the allocated public funds to benefit the foreign patients, brain drain of health professionals due to export of health services, internal brain drain of health professionals due to the entry of foreign health professionals, dual market structure in terms of imports of health services, resource diversion if public funds are allocated to attract foreign direct investment (FDI) in the health sector, and outflow of foreign exchange for profit remittance.

Similar apprehensions have been expressed by others as well. It has been argued that while trading of healthcare services under the various modes of GATS may have positive impacts on the overall health services in a country, the sector is also faced by potential threats likely to emanate from its globalisation (Chanda 2001). Therefore, the impact of trade in health services for equity, access, costs and quality of health services is largely dependent on the policies and safeguards governments put in place, and on the existing conditions in the sector (Chanda 2002).

The issues of challenges with regard to probable increased inequity in the health services, fragmentation of health systems, and further marginalisation of the public sector as a result of increased liberalisation of healthcare system has also been focused in various case studies (Mirza 2004). The importance of proper and adequate consumer protection, competition and regulatory structures has been reiterated in this regard.

It is clear that participating in trade in health services, with or without GATS commitments, holds the potential for a number of concrete benefits, but at the same time also carries some risks in relation to the attainment of objectives of the national health policy. A study on the Tunisian health service by Achouri and Achour (2002) revealed that liberalisation of trade in health services poses both risks including greater pressure on the market for health professionals and destabilising equilibrium between public and private sectors, and benefits such as advancement of quality and efficiency of healthcare along with the access to new technology.

Generally speaking, as experience of the WTO shows, for developing countries and LDCs, it is seen that very often risks are 'real' and benefits are 'potential.' Benefits may not materialise and costs may be high if liberalisation of health sector is not underpinned by sound regulatory discipline, which is carefully tailored towards the achievement of national objectives. For instance, Janjaroen and Supakankunti (2002) analysed the case of Thailand in services for international trade. Thailand did not make any international trading agreements in health services under GATS. They still have significant barriers to trade in the health sector which prevents FDI inflow in the sector, lacks competition at national level, and has established poor healthcare infrastructure over the years. Therefore, the study advocated for free trade in health sector, easing health service laws with minimal impact on the industry, and creating linkage between commercial investment and mobility of personnel as well as regulations that recognise international medical education.

Another study by Gupta *et al*. (1998) analysed the benefits of free trade in health services to India. They have concluded that opening up various areas in health services will benefit the health sector in India, both in short-run and in the long-run, especially through bringing in improvements in the quality and quantity of curative healthcare availability. However, there were barriers preventing free flow of trade at the time of the study. Hence, the paper recommended that rules of the GATS agreement need to be imposed more strongly by increasing the commitments of developed countries towards greater market access and collaboration with developing nations. It should also relax rules concerning short-term movements of medical personnel, standardise rules pertaining to educational qualifications, and establish laws that monitor both local and foreign medical facilities to eliminate illegal practices.

Zarrilli (1998) mentioned that trade liberalisation of the health sector can lead to improved health systems in developing countries by providing additional financial resources, exposing health professionals from developing countries to new techniques and providing them with access to higher qualifications. Also, improvements can follow from introducing innovative management systems in developing countries, upgrading the quality of the health treatments they can provide, especially in the rural areas, and strengthening foreign and domestic competition. León (2000) had also found that modernisation and institutional

change in Chile's health system favoured the internationalisation of health, and so emphasised exchanges and integration among public and private health insurance programmes of sub-regional countries so as to capture the demand created by tourists, and foster the development of provider-centre systems in some specialised and border areas.

There has been concern about the effect of health sector liberalisation on the economically disadvantaged and these have been put into proper perspective. Firstly, GATS does not impose any constraints on terms and conditions under which a host country treats foreign patients. Secondly, there is no legal impediments in GATS that would affect the ability of governments to discourage qualified staffs from seeking employment in private sector, at home or abroad. The deterrent measures might include deposit requirements or guarantees. Adequate regulation can take care of any crowding out effect, which might be to the disadvantage of the resident patients (Chanda 2001).

The potential for trade in health services has increased due to the reduction of geographical barriers to trade and the increase in mobility of potential patients. Health is one of the very few service sectors where developing countries, with adequate qualification, can be competitive exporters under several modes including the Mode 2 of GATS. By capitalisation of inward direct investment from GATS Mode 3 commitments, developing countries attract patients from other developing countries or from adjacent developed countries as well. This is possible for countries with sufficient infrastructural resources, which not only give a local advantage, but can also help ancillary service industries. But unfortunately the interests of developing countries are towards the modes of supply (Adlung and Carzaniga 2002).

Foreign investment in the health services indirectly has a positive effect on income and employment, and may also affect related industries like construction, transport, communication and tourism. This was also hinted by Diaz Benavides (2002) study that showed trade in health services offer possibilities of higher economic contribution of the health sector to the national economy.

On the other hand, Woodward *et al*. (2002) explored the relationship among globalisation, global public goods and health. This paper actually gives importance on economic globalisation as a significant determinant of health and trade in health-related services. Moreover, Woodward (2003) also discussed the profit motive in trading health services, and pointed that the gain of developing country from health services trade is generally lost due to the vast differences of capacities between developed and developing countries.

Sabri (2002) focused more on the greater role of World Health Organization (WHO) in efficient management of the consequences of trade in health services. Furthermore, he insisted on efforts to measure the volume of existing trade in health services and to make reasonable projections for the future.

Other region-wise studies proposed allowing for trade liberalisation with tailored national level policies to govern the health sector. For instance, Widiatmoko and Gani (2002) came up with a suggestion that telemedicine could play a substantial role in reducing the need of both local and foreign health experts in Indonesia. They also emphasised the need for taking measures for equitable access to healthcare from hospitals set up by foreign investment.

Rahman (2000) offered some recommendations for efficient local healthcare services by analysing Bangladesh-India trade in health services. These are: (a) design and strict implementation of quality control measures for medical tests; (b) fiscal policy support to reduce cost of importing medical equipments; (c) review the rules pertaining to fees charged by doctors, and then strictly implement the revised rules; (d) enhanced training facilities for nurses and medical technicians; (e) setting up joint venture medical establishments to facilitate technology and knowledge transfer.

The above mentioned studies reveal that opening up of various areas of health services will be beneficial for countries as a whole in the long-run, in terms of both better quantity (availability) and quality. However, since the institutional and social structure varies from country-to-country, trade liberalisation in the health sector needs a case-by-case review, and not a generalised opinion.

3. OVERVIEW OF HEALTH SECTOR IN BANGLADESH

Bangladesh has made considerable achievement since its independence in 1971 in terms of some healthcare indicators. For example, infant mortality rate (IMR) (per 1,000 live births) has come down to 43 in 2008 from 103 in 1990. Life expectancy at birth is 66 years in 2008 compared to 47 in 1975, and maternal mortality ratio (MMR) is 2.9 (per 10,000 birth life) in 2009 compared to 7 in 1975. As a matter of fact, improved health indicators such as higher life expectancy, low mortality rate along with increased literacy rate and primary/secondary enrolment have contributed to improve the human development scenario in Bangladesh. The Human Development Index (HDI) rose from 0.345 in 1975 to 0.469 in 2010.

However, there are a number of areas where the challenge of strengthening primary healthcare is still very high. More than 60 per cent of the population in the country do not have access to modern primary health services beyond immunisation and family planning. Only 25 per cent of pregnant women receive antenatal care (ANC), and attendant with formal training handles only 24.4 per cent of births. Nutritional status of the population is also among the worst in the world: 40 per cent of the infants born in Bangladesh are classified as low birth weight, and 48 per cent of the children below five years of age are malnourished.

The ratio of patient to doctor in Bangladesh is one of the lowest in the world. The number of population per physician in Bangladesh is 2,785 (DGHS 2010). In 2005, number of physicians per 10,000 people was only 3. Only 55 per cent of the total population has access to health services. Total health expenditure (THE) as percentage of the gross domestic product (GDP) was 3.4 in 2009. The key indicators of Bangladesh health sector and related challenges can be glanced in Box 1.

At present there are 51,993 registered doctors, 25,018 registered nurses, and 23,472 trained midwives in the country. To train the youth as medical practitioners, there are 62 medical colleges, of which 18 are government-owned and 44 are privately-owned. These are, however, not adequate to meet the demand of the population. In fact, the public health system does not have sufficient resources to meet the needs of the large population. Lack of adequate number of hospitals have resulted in long waiting for receiving treatment and

keeping many patients unattended. On the other hand, patients in the private sector hospitals have to pay high fees for getting healthcare.

Box 1: Key Health Indicators and Challenges

Indicators

- More than 38 per cent of the population of Bangladesh is less than 15 years of age
- Proportion of births attended by skilled health personnel is 24.4 per cent in 2009
- Prevalence of low birth weight (weight <2500 grams at birth) is 40 per cent in 2005
- Population per physician is 3,169 in 2005
- National diarrhea case fatality rate is 0.01 in 2010
- About 0.08 per cent annual deaths in Bangladesh is attributed to malaria
- Major diseases among the patients admitted at upazila hospitals are diarrhea (15.1 per cent), assault (11.7 per cent), ulcer diseases (7.2 per cent), pneumonia (5.6 per cent), and enteric fever (3 per cent)
- 75.2 per cent of children (by 1 year of age) are covered by full vaccination under the Expanded Programme on Immunization (EPI)
- Total number of hospital at upazila level is 460 in 2010
- Total number of community clinic is 9,722 in 2010
- Total number of medical college is 62 (Government: 18 and Private: 44)
- Total number of nursing institute is 52 (Government: 23 and Private: 29)
- Number of registered physicians is 51,993 in March 2010
- Number of registered nurses is 25,018 in March 2010
- Hospital beds per 10,000 populations are 3.43 in 2005
- Total health expenditure (THE) as per cent of GDP is 3.4 in 2009

Challenges

- Prevalence of high population growth, maternal and infant mortality rate
- Lack of inter-ministry coordination to enhance health-related project benefits
- Need for increase in per capita health expenditure, availability of medicine and quality of healthcare, and availability of hospitals beds
- Low availability of healthcare for children and women
- Weak delivery system of government public health services at rural areas of the country
- Lack of institutional monitoring and supervision of private-owned hospitals and clinics
- Insufficient number of government medical colleges for capacity building
- Limitations of inter-country regulatory cooperation and cross-border investment
- Challenges associated with Mode 4 are 'restriction on practicing abroad' and 'lack of recognition of qualification of Bangladeshi medical education'

Source: DGHS (2010); http://www.searo.who.int/en/Section313/Section1515_6922.htm

Though Bangladesh fares well in case of some health indicators such as infant mortality, majority of the population is yet to be covered by direct institutional healthcare. In terms of the availability of physical and social infrastructure in the health sector, the country is still lagging behind. The per capita availability of hospitals, doctors and nurses is much lower than the global average, and does not meet the recommended requirements of WHO. The poor status of health indicators in Bangladesh is partly because of the low priority given to healthcare by the government which is reflected through low expenditures on health as a percentage of GDP. The contribution of the government in total healthcare is lower than the private expenditures. Over the years private sector has been increasingly spending on healthcare services.

In 2000, the national health expenditure by both public and private sectors amounted to 2.8 per cent of the GDP. It has increased to 3.4 per cent in 2007. Public expenditure on health as percentage of total expenditure on health was 38 per cent in 2000, which has declined to 33.6 per cent in 2007. Government health expenditure as percentage of the total government expenditure was 7.2 per cent in 2000; it has increased to 8 per cent in 2007. In 2000, the total government health expenditure per capita was USD 3, which has increased to USD 5 in 2007 (WHO 2008). These figures are the lowest even among the South Asian regional countries.

Currently, Bangladesh's healthcare relies significantly on the private sector which contributes more than 68.3 per cent of THE. At present, the Government of Bangladesh (GoB) puts priority on cost sharing, decentralisation of authority, decision making and programme implementation at the peripheral level, promotion of community participation, delivery of an essential services package to the poor, and mobilisation of financial resources by negotiating with donors. The government received about 8 per cent (2009) of THE from multilateral and donor funds (Table 1). Most of the foreign support is provided as technical assistance and for capacity building and development of health sector projects. A number of non-government organisations (NGOs) also provide healthcare, at a limited scale though.

Table 1: Healthcare Expenditure in South Asia and Other Countries

Country	Public-Private Composition of Healthcare Expenditure (%)				THE as % of GDP		Per Capita THE (PPP Intl. Dollars)*		Per Capita Government Expenditure on Health (PPP Intl. Dollars)*		External Resources for Health as % of THE	
	2000		2009		2000	2009	2000	2009	2000	2009	2000	2009
	Pub	Pvt	Pub	Pvt								
South Asia												
Bangladesh	39.0	61.0	31.7	68.3	2.8	3.4	22	48	9	16	6.9	7.9
India	27.5	72.5	32.8	67.2	4.6	4.2	69	132	19	43	0.5	1.1
Nepal	24.9	75.1	35.3	64.7	5.1	5.8	43	69	11	25	15.2	13.7
Pakistan	21.2	78.8	32.8	67.2	3.0	2.6	47	63	10	21	0.8	3.7
Sri Lanka	48.3	51.7	45.2	54.8	3.7	4.0	101	193	49	87	0.0	2.0
Bhutan	79.3	20.7	81.9	18.1	6.7	5.5	165	274	131	224	21.3	7.6
Afghanistan	27.6	72.4	21.5	78.5	8.3	7.4	21	69	6	15	0.6	17.5
Maldives	46.8	53.2	64.9	35.1	8.7	8.0	242	412	113	267	2.2	1.2
Developing Countries												
Brazil	40.3	59.7	45.7	54.3	7.2	9.0	494	943	199	431	0.5	0.0
China	38.3	61.7	50.1	49.9	4.6	4.6	107	309	41	155	0.0	0.0
Singapore	44.9	55.1	41.1	58.9	2.8	3.9	900	2086	404	858	0.0	0.0
Thailand	56.1	43.9	75.8	24.2	3.4	4.3	165	345	92	261	0.0	0.5
Developed Countries												
USA	43.2	56.8	48.6	51.4	13.4	16.2	4703	7410	2032	3602	0.0	0.0
Canada	70.4	29.6	68.7	31.3	8.8	10.9	2519	4196	1772	2883	0.0	0.0
Norway	76.2	17.0	78.6	15.6	8.4	9.7	3032	5395	2310	4237	0.0	0.0
Switzerland	55.4	44.6	59.6	40.4	10.2	11.3	3212	5072	1780	3021	0.0	0.0

Source: http://apps.who.int/ghodata/?vid=1900#
Note: Local currency units are converted to international Dollars using the purchasing power parity (PPP).

From the above discussion on health expenditure scenario, it is obvious that there are scopes for investment by the private sector and trade in the health sector in Bangladesh. The health indicators also highlight the need for increased resources for the development of the health sector. The dependence on private sector and external sources arises from the fact that with limited resources, the GoB has to meet up competing priorities. Hence, it is not possible for the government to provide quality healthcare services for everyone. On the other hand, there is a growing affluent class which can afford high quality expensive health services. Thus resources are needed not only for basic healthcare, which is primarily the responsibility of the government, but also for improved and specialised health services. One of the ways to bridge the resource gap as well as services gap is to increase collaboration within the countries in the region.

4. HEALTH SERVICES UNDER GATS AND COMMITMENTS OF BANGLADESH

GATS allows the Member countries to assume legally binding commitments regarding trade in different services sectors. Commitments are laid down in individual country schedules of the Member countries, and they can adjust the schedules according to their own domestic policy objective and constraints. The schedules of service commitments are longer and more complex than tariff schedules for trade in goods.

Health is among the 12 service sectors, which have come under the purview of the WTO-GATS. The broad groups of GATS service sectors include: (i) business and professional services; (ii) communications; (iii) construction and related engineering services; (iv) distribution services; (v) education services; (vi) environmental services; (vii) financial services; (viii) health services; (ix) tourism and travel related services; (x) recreational, cultural, sporting services; (xi) transport services; and (xii) others. Under the agreement which has adopted an offer and request approach for negotiation, all countries are to request market access and also offer commitments to open certain sectors using a positive list approach. According to the agreement, and the negotiating guidelines and procedures, the schedule of commitments of a country provides a list of limitations on market access and national treatment across four modes of supply. Mode 1 refers to the trade in services across borders and is the most analogous to regular trade in goods. Mode 2 refers to the trade in services when the consumer moves abroad to consume the services. Mode 3 refers to the establishment of commercial presence, such as branch offices, representative offices, joint ventures and subsidiaries, and is analogous to FDI. Mode 3 contributes 55-60 per cent of global trade. Mode 4 refers to the trade in services when service provider moves abroad temporarily to deliver the service in the host country. The contribution of Mode 4 (movement of natural persons) to the global trade in services is quite insignificant till now.

In case of the health sector also, four modes of service delivery in the health sector are identified. Mode 1 covers services that provide diagnosis or treatment across the national border. Cross-border supply of health services include shipment of laboratory samples, diagnosis, and clinical consultation via traditional mail channels, as well as electronic delivery of health services, such as diagnosis, second opinions and consultations. With the advancement in information and communication technology (ICT), processing of medical claims and medical transcription services has also come up in a major way. Mode 2 is to capture consumption undertaken outside the home country like movement of patients. This

mode enlists services whereby patients arrive from other parts of the world. This is also popularly called as medical tourism. Mode 3 is commercial presence through building of establishments such as hospitals, clinics, diagnostic and treatment centres and nursing homes in other countries. Mode 4 represents movement of natural persons or professionals from one country to another. The Mode covers movement of health personnel including physicians and specialists. It is pointed out that the sub-sectors of hospital services and other human health services fall under the GATS in health-related, and social services; other services which are also health-related, but fall under the sub-category of professional services are medical and dental services, services provided by midwives, nurses, physiotherapist and paramedical personnel (Kategekwa 2008). Table 2 provides some examples of health services under various modes.

Table 2: Distribution of Health Services across Various Modes of Delivery

Mode	Description	Examples
Mode 1	Cross-border supply	Electronic delivery of services including telemedicine, telepathology, telesurgery, telepsychiatry, teleradiology and other analysis and diagnosis of laboratory tests; remote consultations and surveillance; claim processing; medical transcription, shipment of laboratory samples; remote education; and the purchase of health insurance
Mode 2	Consumption abroad	Movement of patients/medial tourism
Mode 3	Commercial presence	Investment in hospitals/establishment of healthcare providers or firms in the healthcare sector outside their home nation through FDI in equity or non-equity forms
Mode 4	Presence of natural persons	Presence of health professionals in another country

Source: Prepared by the authors.

As per the WTO's services classification list (MTN.GNS/W/120) followed by most WTO Members, for scheduling their commitments, health services consist of two sub-sectors: Hospital Services (*Provisional Central Product Classification (CPC) 9311*) and Other Human Health Services (*Provisional CPC 9319 other than 93191*). Hospital Services include services delivered under the direction of medical doctors chiefly to in-patients, aimed at curing, reactivating and/or maintaining the health status of a patient. Thus hospital services comprise medical and paramedical services, nursing services, laboratory and technical services including radiological, anaesthesiological services, etc. Other Human Health Services include ambulance services, residential health facilities services other than hospital services, and other human health services meaning services in the field of morphological or chemical pathology, bacteriology, virology, immunology, etc., and services not elsewhere classified, such as blood collection services. Table 3 provides a summary of commitments made by countries in South Asia.

Bangladesh has so far made very limited commitments under GATS. Commitments were made to liberalise only two sectors, namely five-star hotels under tourism and travel-related services during the Uruguay Round, and telecommunication services after the completion of Uruguay Round. But the health sector is totally absent from the list of commitment.

Table 3: Sector-specific Commitments and Limitations

Sector/Sub-Sector	Limitations on Market Access	Limitations on National Treatment
Bangladesh		
Sector not scheduled		
India		
Hospital Services (CPC 9311)	1) Unbound[a] 2) Unbound 3) Only through incorporation with a foreign equity ceiling of 51 per cent 4) Unbound, except as indicated in the horizontal section	1) Unbound 2) Unbound 3) None[b] 4) Unbound, except as indicated in the horizontal section
Nepal		
Hospital Services (CPC 9311) and direct ownership and management by contract of such facilities on a 'for fee' basis	1) None 2) None 3) None, except only through incorporation in Nepal and with a maximum foreign equity capital of 51 per cent 4) Unbound, except as indicated in the horizontal section. Medical experts can work with the permission of Nepal Medical Council for a maximum of one year	1) None 2) None 3) None 4) Unbound, except as indicated in the horizontal section
Pakistan		
Hospital Services (CPC 9311)	1) Unbound (due to lack of technical feasibility) 2) None 3) a) As in measures applicable to all sectors b) Subject to Pakistan Medical and Dental Council Regulations 4) Unbound, except as indicated under horizontal measures	1) Unbound (Unbound due to lack of technical feasibility) 2) None 3) None 4) Unbound, except as indicated under horizontal measures
Sri Lanka		
Sector not scheduled		

Source: http://tsdb.wto.org/simplesearch.aspx
Note: [a]'Unbound' means no commitment has been taken by the country, and also for the particular sub-sector and Mode of Supply, there is no binding of the country.
[b]'None' means there are no limitations.

However, liberalisation has taken place autonomously in sectors such as the financial sector. In order to meet the overall development and economic objectives, Bangladesh has taken policies to promote foreign investment in both manufacturing and services sectors. Since the 1990s, Bangladesh economy is also integrating with the global economy at a fast pace. As part of the structural adjustment programmes during the late 1980s and early 1990s, Bangladesh undertook a number of initiatives towards trade liberalisation and trade promotion to stimulate exports and encourage investment in the export-oriented activities. The major objectives of these reforms were – removal of anti-export bias, introduction of incentives for exports, and facilitation of participation in global labour market. The policies of trade liberalisation were implemented through reduction of tariff rates, elimination of quantitative restrictions, and reduction of tariff dispersion. This has resulted in the increased market access of foreign products through reduction in tariff rates, accelerated growth of exports from the country, increased volume of FDI, and participation of a growing number of Bangladeshi workers in the global labour market.

To promote private investments in the healthcare sector, the government has exempted all duties from the imports of medical equipments and machineries. In general, the incentive structure for the foreign investors include measures such as full repatriation of profit, tax holiday for five to seven years depending on the location of the investment, unrestricted exit policy, and avoidance of double taxation. The *Foreign Private Investment (Promotion and Protection) Act 1980* governs the legal framework for foreign investment in Bangladesh. The Act provides non-discriminatory treatment between local and foreign investments, protection of foreign investments from expropriation by the state, and ensures repatriation of profits and proceeds from sales of shares. *Industrial Policy 2010* aims at promoting FDI in order to bring about technology transfer, efficiency and management development, and enhanced marketing skills. According to the Industrial Policies of 1999, 2005 and 2010, foreign investors enjoy the same incentives as domestic entrepreneurs with respect to tax holidays, accelerated depreciation allowances, concessional duties on imported capital machinery and other measures. The convertibility of Bangladeshi Taka (BDT) for current account transactions has facilitated foreign investment by eliminating the requirement to obtain prior approval from the central bank, the Bangladesh Bank, on current account transactions. There is no limitation pertaining to equity participation by foreign investors. Investment can be made independently or through joint ventures, either with local or public participants.

5. PROSPECTS FOR HEALTH SERVICES TRADE FOR BANGLADESH WITHIN SOUTH ASIA

In Bangladesh health sector is yet to gain adequate importance in the national economy in terms of its trade potential. Although GoB has not committed to open the health services market under GATS, commercialisation of the sector is being promoted since the 1990s. This has resulted in mushrooming of private clinics and hospitals in the urban areas, and brought about increase in imports of health service equipments and technology. Reduced tariff on imports has fostered investment in the healthcare sector. Currently trade in health services in Bangladesh is conducted mostly under Mode 2, and practice of other modes is quite insignificant. This will be clear from the following discussion.

Mode 1

Telemedicine links do not exist between hospitals in Bangladesh and other South Asian countries, though some hospitals in the region maintain contact with Indian establishments for teleconsultation and telediagnostic services. Bangladesh can identify potential opportunities in remote monitoring of patients through telemedicine services. Of course, in order to provide telemedicine services, Bangladesh has to invest in high-end training and use of specialised equipments.

Mode 2

Bangladesh is a net importer in terms of Mode 2 of health services. It imports health services from various countries such as India, Thailand, Singapore, UK and USA. Patients from Bangladesh go mostly to these countries for check-ups and treatment. A few foreign doctors and nurses are working in private hospitals in Bangladesh with the permission from GoB.

The country also exports some health services through doctors and nurses, mostly working in the Middle East countries such as United Arab Emirates (UAE), Saudi Arab, Oman, Kuwait, Qatar and Iran. The establishment of Apollo and Square Hospitals in Bangladesh, international chains with Apollo Hospitals of India and Bumrungrad Hospital of Thailand respectively, is a step towards providing health services of global standards. The objective of such ventures is to cater to the large number of patients travelling to India and other neighbouring countries for treatment.

The reason for such outflow of patients is not only the increase in number of affluent people in the country, but also lack of integrated health services which includes qualified human resources, modern medical equipments and reasonable consulting fees. Besides, Bangladeshi patients go to India because of the lower cost of treatment compared to other countries such as Thailand and Singapore; factors such as cultural and linguistic similarities and geographic proximity between Bangladesh and India are also important reasons for such preference. A number of Bangladeshi patients also go to Nepal for eye treatment.

Mode 3

Given the increased demand for health services in Bangladesh, several other Indian hospitals are considering about establishing their presence in Bangladesh. For example, the BM Birla Heart Research Centre of Kolkata expressed interest in setting up its branches in two cities of Bangladesh – Chittagong and Dhaka. Also the AMRI Hospital of Kolkata are interested to set up a branch in Bangladesh. Patients from Bangladesh go for treatment to a number of cities in India, such as Kolkata, Delhi, Mumbai, Banglore and Chennai. Among these cities Kolkata is closest to Bangladesh geographically and linguistically.

There can be scopes for regional cooperation in health sector which are not linked to services but products. Drugs and pharmaceuticals, medical devices and technology, and health insurance are some examples. In this case again, India is ahead of other countries in the region. The GE office in Bangalore not only produces medical products, but also delivers services to Bangladesh and Sri Lanka. Since Bangladesh has very good capacity in case of pharmaceuticals, she can export medicines in the neighbouring countries at an affordable price. As an LDC, Bangladesh enjoys the flexibility of exporting medicines to other countries, and do not have the obligation for patenting till 2016. However, harmonisation of standards and certification procedures are essential to increase accessibility of pharmaceutical products.

Mode 4

Medical education is an area where Bangladesh has advantage over some of the SAARC countries. Students from Nepal are enrolled at medical colleges in Bangladesh. Collaborative medical research and sharing of information and expertise through regional conferences, seminars, and exchange of health professionals and academics are potential areas for further collaboration within the South Asian region. Bangladeshi doctors have been working in several countries. Degrees provided by the medical colleges at the graduate and post-graduate level are recognised in the importing countries.

6. CONSTRAINTS OF HEALTH SERVICES TRADE IN SOUTH ASIA

In spite of having immense potentials for expanding regional collaboration in the field of health, there are challenges as well. There are some problems which are particularly associated with the specific modes of GATS. Challenges prevail at both government and private sector levels which restrict the scope for medical tourism and investment initiatives. These challenges are infrastructural, regulatory, perception-related, logistical and cultural. Challenges associated with each mode of services are discussed below.

Mode 1

In case of telemedicine within the South Asian region, technological constraints and concerns regarding privacy act as barriers. Poor economic condition of the region hinders technological advancement, as there are high initial costs of setting up the telemedicine infrastructure among most of the South Asian countries. This also poses risk of diversion of resources from basic preventive and curative healthcare services as telemedicine is highly capital intensive. Difficulties may arise from arranging payments for telemedicine services and reimbursing insurance. Lack of privacy and security regulations governing telemedicine poses risk of a rise in legal liability issues, as there is no guarantee of maintaining the secrecy of medical information.

Another major concern is the resistance from the healthcare providers themselves. Faced with the threat of increased competition from medical professionals abroad through telemedicine, there is a perception that their demand in the local healthcare market may be replaced. This makes telemedicine even harder to be introduced and implemented in host countries. Complications with regard to recognition of qualifications of health professionals and shortage of qualified human resources also limit the scope of trade in health under this Mode. In addition, there is an issue of trust and content acceptance among the healthcare service seekers in receiving medical advice through telemedicine (Dacanay and Rodolfo 2005). One way of overcoming this could be to implement a partnership agreement between a local healthcare provider and a reputable institution in the target market (SANEI 2010).

Mode 2

The prospect of medical tourism has also been facing numerous obstacles towards its flourishment. To promote medical tourism the mode of financing should be made easier first of all. Closed insurance sector in South Asian countries has been a problem. So far promotion of regional insurance has been a neglected sector which needs to be promoted to expand medical tourism. Issues such as visas and airline connectivity have been problems which restrict the mobility of patients to a large extent. For example, due to complications of visa processing, patients from Bangladesh travel to India mostly on tourist visa; and hence, the number of outflow of patients from Bangladesh is never accurate. Informal channels are also adopted to avoid complications with regard to financing and obtaining approval for treatment overseas. Pre- and post-consultation with the doctors from neighbouring countries has not eased enough. Moreover, the follow-up treatment requires several foreign visits which might not be a very feasible option for most of the people of the

region. Recently, medical legal cases are increasing as a result of malpractice of physicians abroad. This phenomenon is discouraging medical tourism as there is always some barriers to penalise someone of another country. This requires formulation of government policy on regional cooperation in trade of health services. Besides, overall tourism industry in the South Asian region is not developed. Tourism promotion through various policies and marketing strategy is necessary, in addition to infrastructural development for enhancing intra-regional medical tourism. Another important aspect deterring medical tourism is the legal restrictions on currency using in other countries. Due to hassle in the transaction system, informal arrangements for payment is widely prevalent for medical tourism, and thus, number of patients travelling from one country to another is underestimated (for example, in case of India and Nepal).

Mode 3

Even with liberal FDI regime in South Asian countries, joint ventures face problems of getting employment visas. There is resistance by professionals in the country to the hiring and relocation of doctors from the region. Resistance also persists in the telemedicine sub-sector which constrains the scope for its expansion within the SAARC region. There are economic concerns relevant to the health industry in South Asia along with poor infrastructure and insufficient regulation. Some believe, excessive FDI inflow in the health sector will not only stifle local healthcare practitioners' service, but also add to concerns of capital flight and profit outflow. This can deteriorate net income from abroad and lead to a negative impact on the balance of payments position of the country. On the supply side, due to statistical inadequacy, foreign investors often cannot make clear projection as to whether patients in these countries can afford private treatment, and therefore they avoid investing in healthcare. Moreover, South Asian countries face political instability from time to time which threatens safety of the investment.

Mode 4

Issues involving income tax, residence permits, difficulties with accreditation or recognition of foreign professional qualifications, foreign exchange controls involving repatriation of earnings (Dacanay and Rodolfo 2005), as well as other government policies (e.g. licencing and documentation requirements) restrict potential trade in health services in South Asia. Till now none of the South Asian countries have committed anything for facilitating the movement of health professionals. Strict policies and complicated system for granting visa affect the regional mobility of professionals, which restrict their attendance in seminars and conferences. Quite often, they have to attend meetings as general tourists. There is also much demand for qualified health professionals and specialists in South Asia. Given the situation, arrangements can be made for health professionals of South Asian countries to go to Indian institutes for higher studies and training.

7. CONCLUSION AND POLICY IMPLICATIONS

Discussions in the preceding sections indicate that trade in health services is liberalised to some extent within the SAARC region. However, as is the case with socioeconomic situation, the nature and extent of trade in services are also not homogeneous across the region. This

indicates that there is a scope for increased cooperation in the health sector among the South Asian countries. In view of the developmental aspect and commercial opportunities, regional integration in the health sector can be explored in the following areas. In this respect a number of related challenges are also discussed which have important policy implications.

7.1 Promoting Telemedicine

Except for Bangladesh and Sri Lanka, telemedicine services are provided by India, Nepal and Pakistan. Most of these services take place within the country, between urban and rural areas. Lately, they are also practicing telemedicine between hospitals and universities and between hospitals in the region. Private hospitals and NGOs are also engaged in telemedicine consultations. However, due to the inadequacy of advanced technology and limited experience in telemedicine services, the sector is yet to take off. Telemedicine is a promising area for regional trade integration in health services since cross-border trade through telemedicine allows greater healthcare availability from at least two perspectives. First, specialised treatments can be performed even in places where required medical professionals are not present physically. This has great potential for better delivery of healthcare services in South Asian countries, where specialists are concentrated mostly in larger hospitals, often located at big cities. Second, telemedicine enables continuous availability of healthcare without time barriers, and minimises the congestion for treatments.

However, the mechanism of supply of telemedicine is not systematic and not institutionalised in the region. The volume of services is primarily determined by individual connections with hospitals and doctors. Also, due to lack of adequate communications infrastructure, and absence of proper coordination and integration with foreign health service providers, problems remain in the areas of quality assurance, reliability and competitive cost structure. These predicaments have to be removed in order to create a niche in medical transcription and billing, carrying out surgeries in hospitals in South Asian countries with the guidance of renowned foreign surgeons through state-of-the-art video conferencing facilities, or providing diagnostic facilities. Also the privacy and confidentiality of patient information have to be protected through a legal framework.

In spite of the challenges, there are significant benefits that can be achieved by SAARC countries through telemedicine service. Not only will the service act as a bridge between patients seeking technical medical advice and the international professionals with the relevant experience to dispose off similar advice, but it can also enable individuals in remote areas to have access to healthcare. Quality of healthcare services can improve and telemedicine can serve as an important source through which technical training can be imparted on the less-skilled human resources and create employment opportunities in these countries. Services can be made more cost-effective and the benefits may trickle down to the medical services provided in the local markets.

7.2 Facilitating Medical Tourism

Resolving regional payment arrangements and settling of financial matters of different kinds are pre-conditions for encouraging medical tourism. First is the issue of acceptance of a common health insurance product within the region. The premium for international health insurance is very high and unaffordable by most patients in South Asia. Therefore, a framework for portability of the health insurance needs to be developed so that patients can use an insurance policy within the region for treatment. Second, the modality of payment of bills should also be made easier by fixing rates for various types of treatments and procedures at various hospitals of the region. Governments should take initiative to discuss various modes of payments including the possibility of reimbursement of bills, with hospitals, banks and insurance companies in the region.

Besides financial matters, various support services such as accommodation, transportation and other logistic are attached to medical tourism. Promotion of medical tourism requires availability of related services at an affordable price. This is important also because some patients need follow up consultations to be cured fully which may be discouraged due to high taxes and rents. Part of the costs can be reduced through the improvement of telemedicine.

Health tourism in the South Asian countries can also attract patients from the developed countries. Cost of treatment by qualified medical professionals without long waiting time is a major determinant for people willing to go abroad for medical treatment. USA alone has over 46 million uninsured people and even those with insurance often cannot afford treatment because of high deductibles, co-pays and the exclusion of pre-existing conditions from coverage (Turner 2007). Statistics shows the wide disparity in the average costs of some medical procedures between USA and India. South Asia can be the destination for medical treatment of large number of foreign patients with limited income. Improved health services by the South Asian countries through regional cooperation can attract these potential patients from around the world. As in the case of general tourism, marketing of health tourism has to be done aggressively. Medical tourism requires investment in the health sector as well as in the infrastructure. Political stability and good law and order situation are also important determinants for increased medical tourism.

7.3 Cross-border Investment in Health Sector

Given that there is a huge scope for improvement of health infrastructure in South Asia, cross-border investment is definitely a potential area for collaboration within the region. A number of international hospital chains and health service providers have shown interest for joint collaboration in a number of South Asian countries. Hospitals from within the region have also come forward to expand their establishments in the SAARC region. These private sector initiatives must be supported by government measures through appropriate regulatory measures. As governments of the region have limited resources to allocate for the development of the health sector, investments through public-private partnerships (PPP) should be initiated. This, of course, has to be supported by necessary policy measures taken by respective governments.

The issue of two-tier healthcare system has to be kept in mind and dealt with due sensitivity. Advanced medical services provided by the private and joint venture hospitals are expensive and not affordable by a large segment of the population in the region. Thus the poor will have to depend on the government hospitals which traditionally provide low quality service, while the richer section will avail the modern healthcare facilities provided by the private sector. This is apprehended to widen the already existing inequality between the rich and the poor. Therefore, the role of the government in providing basic healthcare services at free or low cost to the poor and in reducing inequality cannot be undermined. Though trade liberalisation does not promote subsidisation, given the fact that access to healthcare is a basic right of human being, cross-subsidisation may be allowed in the region to support healthcare to the poor citizens.

Another problem related to modern hospitals through private investment is that they hire the best health professionals at a higher pay from within and outside the country. As a result there may be shortage of good doctors and other health professionals for the state-owned hospitals. The high financial reward opportunity also encourages health professionals to seek employment outside the country which may cause brain drain in the country. This brings the issue of regional cooperation in the area of capacity building of health professionals.

7.4 Capacity Building of Health Professionals

The challenge of human resource shortage can be overcome by increased capacity building of health professionals both in numbers and skills. In view of the high demand of qualified health professionals all over the world, countries tend to lose their trained doctors, nurses, technicians and other health personnel to the rich and developed countries on a continuous basis. All South Asian countries are exporters of health professionals. Establishment of the state-of-the-art hospitals in the SAARC region will also attract skilled health professionals from the public sector. Bringing medical personnel from the developed countries will be very expensive which may affect the competitiveness of the health services in South Asia through reduced cost effectiveness. Therefore, sufficient investment in medical education is needed on a continuous basis to address the shortage of human resources in healthcare.

Capacity building should also be done through skills transfer by way of short-term on-the-job training, participation in seminars, conferences and workshops and other exchange programmes of hospital staffs. Though a large number of health professionals do participate in these types of programmes, these are mostly held in the developed countries and for the qualified doctors. There is a shortage of such activities within South Asia which could give opportunities for health personnel in the region to interact with their counterparts of the region. Scholarships for medical education within the region is available, but at an insufficient level. Governments and private sector may come forward to fill this gap. Additional resources for such activities may be explored from the development partners as well.

In order to operationalise the idea of capacity building through regional cooperation and skills transfer through employment under Mode 4, issues such as visa and harmonisation of professional standards are pre-requisites. Complications in getting visa to travel within South

Asia also constrain medical tourism which compels patients to travel as general visitors and accept risks of using informal channels of payment for medical treatment. Recognising the political sensitivity of making SAARC a visa-free region for its citizens, initiative has to be taken to streamline and minimise the visa requirements for travelling patients. A regional database for travelling patients may be prepared for more transparency.

Efforts towards harmonisation of professional standards and recognition of qualifications of South Asian health personnel and accreditation of hospitals and other medical establishments are essential to improve the reputation of the health services in the region which would increase health tourism.

Finally, in order to expand and improve health services within the region, inter-governmental dialogue on the adoption of a possible vision for the health sector is essential. The SARRC Agreement on Trade in Services (SATIS) is a leap forward. However, SAARC countries suffer from political strains with each other on several counts. Therefore, as in case of any other development activities, improved cooperation in the health sector also critically hinges on the political relations among the governments of the region.

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Annex Tables

Annex Table 1: Trend of Total Healthcare Expenditure

Fiscal Year	Total Health Expenditure at 2007 Constant Prices (Tk. Crore)	Growth Rate of Expenditure over Previous Year (%)	Share of Expenditure Each Year as Percentage of GDP (%)
1998	7896.6	6.1	2.7
1999	8455.4	7.1	2.7
2000	9179.6	8.6	2.8
2001	10325.6	12.5	2.9
2002	11165.2	8.1	3.0
2003	11586.7	3.8	3.0
2004	12662.4	9.3	3.1
2005	13607.5	7.5	3.2
2006	15258.8	12.1	3.3
2007	16089.9	5.4	3.4

Source: DGHS (2010).

Annex Table 2: Contribution of Total Health Expenditure (THE) from Different Sources in Bangladesh: FY1997-FY2007

Fiscal Year	Public Sector		Household		Private		Insurance		NGO		Development Partners		Total THE
	Crore Tk.	% of THE	Crore Tk.	% of THE	Crore Tk.	% of THE	Crore Tk.	% of THE	Crore Tk.	% of THE	Crore Tk.	% of THE	Crore Tk.
1997	1768.2	36.0	2757.3	57.0	56.2	1.0	3.5	0.0	54.8	1.0	230.0	5.0	4869.9
1998	1834.1	34.0	3105.5	58.0	60.5	1.0	4.1	0.0	68.5	1.0	287.5	5.0	5360.2
1999	1929.2	32.0	3507.1	59.0	48.7	1.0	4.7	0.0	84.9	1.0	368.8	6.0	5943.3
2000	2021.7	31.0	3871.9	59.0	91.0	1.0	5.4	0.0	101.9	2.0	457.8	7.0	6549.7
2001	2312.8	31.0	4345.6	59.0	59.4	1.0	9.7	0.0	126.0	2.0	565.9	8.0	7419.3
2002	2522.3	30.0	4894.4	59.0	65.7	1.0	11.7	0.0	126.5	2.0	677.2	8.0	8297.8
2003	2481.0	28.0	5446.1	61.0	87.1	1.0	14.2	0.0	142.2	2.0	800.4	9.0	8970.9
2004	2931.6	29.0	6107.8	60.0	85.4	1.0	16.7	0.0	157.9	2.0	923.5	9.0	10222.9
2005	2991.8	26.0	7450.6	64.0	93.7	1.0	22.4	0.0	176.5	2.0	973.4	8.0	11708.5
2006	3869.6	28.0	8641.9	62.0	110.0	1.0	25.6	0.0	195.4	1.0	1053.0	8.0	13895.5
2007	4131.8	26.0	10345.9	64.0	132.5	1.0	31.4	0.0	209.2	1.0	1239.1	8.0	16089.9

Source: DGHS (2010).

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