

FINAL REPORT
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***HEALTH TOURISM AND RELATED SERVICES:
CARIBBEAN DEVELOPMENT AND INTERNATIONAL
TRADE***

Submitted to the Regional Negotiating Machinery (RNM)

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CAMC	Caribbean Association of Medical Councils
CARICOM	Caribbean Community
CBEI	Caribbean Business Enterprise Initiative
CDB	Caribbean Development Bank
FTAA	Free Trade Area of the Americas
GATS	General Agreement on Trade in Services
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
IDB	Inter-American Development Bank
OECD	Organization of Economic Cooperation and Development
PAHO	Pan American Health Organization
RNM	Regional Negotiating Machinery
UNCTAD	United Nations Conference on Trade and Development
WHA	World Health Assembly
WHO	World Health Organization
WTO	World Trade Organization
NDC	National Development Corporation
JAMPRO	Jamaica Promotions
TIDCO	Tourism and Industrial Development Corporation
BIA	Bahamas Investment Authority

EXECUTIVE SUMMARY

The study focuses on the prospects for developing trade in health tourism services and identifying trade negotiation objectives and strategy. The specific areas of health tourism that are under examination are convalescent care and rehabilitation; health and wellness programmes, such as use of spas, etc; drug and alcohol dependency programmes; the use of local health services by tourists; cosmetic surgery; and telemedicine.

The source of comparative advantage in the above areas seems to lie in proximity and access to the target markets, relatively strong intellectual capital, an established hospitality industry, and ambient environment. It was not possible to verify the suggested areas of competitiveness with careful quantitative analysis or even some simple international price comparisons of the relative costs of specific services. Eventually there will be a need for the latter.

Several benefits to trade in health services were noted such as foreign exchange, a reduction in the need for public resources, consumer gains, and better management. The benefits of trade in health services however, need to be balanced against potential negative impacts. Increased competition in this market will not necessarily lead to improvements in efficiency, equity, or quality. Quality of care may be affected as there are few regulations and controls within the health sector. There are many barriers to entry and exit in the health care market. In addition, there is a great deal of uncertainty and lack of information in the health care marketplace.

Equity is an important social goal and public health services are an essential input into achieving that objective. Some policy makers are concerned that by providing health services to visitors, scarce public resources will be reallocated away from much needed public health programs. The local population will not be provided with access to quality health services. Crowding out can only occur when public funds are used to develop trade in health services. However, government's role could be to encourage and monitor private sector development of health services that could be traded on the international market. These two tracks for health services can be developed simultaneously, and in a mutually reinforcing way.

The main barriers to the development of trade in health services are the nature of medical practice, financing of care and insurance coverage, accreditation and standards, immigration and foreign exchange requirements, and competition within the region. Experiences in the region and trends worldwide however, suggest that there are many opportunities for trade in health services in the English-Speaking Caribbean. The English-speaking Caribbean has many characteristics that could facilitate successful development of health tourism. These include attractive climate and environment; well-trained health practitioners; reliable telecommunications and good transport infrastructure; excellent hotel and tourism services; an educated population; and, lower labor costs than most developed countries.

Health tourism has been thriving in islands with an expanding and booming tourism industry and a culture and economy that is geared to looking at

tourist markets. The Bahamas is a good case in point where there are a range of health tourism activities associated with the turnaround in tourism in the last few years that has resulted from a surge of FDI. .

There appears to be a growing interest and activity in the development of spas and complementary healing practices in response to increased demand from the international marketplace. However, much of the development has remained relatively fragmented, small scale with most of the progress in the range of wellness services located in the tourism infrastructure.

Based on supply and demand factors, the study advocates the development of a strategic plan with all stakeholders involved. Each individual country will have to decide who would lead the development strategy and be accountable for the development objectives being achieved. Each country in moving forward will need to complete a stakeholder analysis of or at least evaluate the various interests, resources and potential problems associated with trade in health tourism to determine the most appropriate role for each player in the formulation and implementation of the development strategy.

The role of regional agencies involved in trade, tourism and health services will also need to be explored in terms of contributions to common issues of design, development and implementation in collaboration with other national and international agencies and firms. Strengthening of the regional trading of health services (as for instance, the sharing of services as discussed in PAHO) could play a useful role in managed liberalization. Regional agencies can act as regulators by creating standards for industry regionally and internationally, including the negotiation of intra-regional trade policies as they affect trade in health services.

Domestic Policy Issues

1. Foreign Direct Investment

As regards foreign investment, the rapid growth in hotel investment in the Bahamas is related to the large investment in infrastructure. It is also connected to the fact that foreign investors are managing and running the businesses, marketing through the international networks and providing significant amount of training and employment to local residents. This would imply that adequate arrangements for the movement of natural persons are also critical.

Policy, regulatory, institutional and legislative barriers to foreign investment in health tourism have been highlighted in the region such as uncertainty and lack of transparency concerning work permits, Alien-Landholding Acts, and visas as well as the absence of information on government policies and regulations pertaining to the export of health care services. The lack of a set of formal regulations readily available to interested investors and governing standards for medical care, licensing, quality assurance and control procedures, clinical practice, and facilities operations has been particularly underscored. Policies regarding the licensing and approval of new technologies, treatments, and drugs were also underscored.

Taxes in relation to the purchase of property and the import of high technology medical equipment were also noted as another deterrent of foreign investment. Labor laws are also seen as problematic for expatriates. It is difficult to obtain work permits and the uncertainty of renewal makes many foreigners reluctant to invest. In addition, the legal and regulatory constraints are subject to both interpretation and discretion. Approval times also involve a lot of uncertainty.

While countries are making efforts to eliminate these barriers, the question has been raised as to whether it is sufficient to eliminate barriers or is it also necessary to provide incentives? The debate on the granting of incentives to correct market failures has raged over the years without any firm conclusions and guidelines. The conditions under which incentives work or do not work are still not known with any precision.

An examination of incentive legislation in the six countries studied indicated that none of them offered special financial incentives for the health services industry but Governments in the region have the inherent right to take "off-the-book" decisions to offer special financial incentives. In an imperfect world, special incentives never go away, and, by far, the greatest competition for investment is among developing countries. The evidence from the Bahamas case study suggests that FDI can make a big difference and is responsive to liberal policies. Bahamas however, offered a range of incentives for hotel investment as laid out in the Hotel Encouragement Act and supporting regulations managed by the Office of the Prime Minister (OPM) through the Bahamas Investment Authority.

In the absence of an agreement among CARICOM countries as well as internationally acceptable conventions to limit unhealthy competition in the granting of incentives, special incentives will continue to stimulate investment in the region. The case of the Bahamas in hotel investment seems to illustrate that in spite of liberal policies to foreign investment that reduced barriers, special incentives were still necessary. The evidence in the health sector is not conclusive enough to suggest that countries could avoid using special sector-specific incentives.

In addition, in the health sector, financial investment incentives should be considered as only part of the total incentive package, in that liability and risk management issues could come up long after the investor has reaped the start-up benefits.

2. Policies to ensure universal access

The question of meeting the social goals in the health sector in the context of freer trade and in a search to increase exports of health services comes down to whether complementary policies can be devised and implemented which ensure that access for the poor is not jeopardized. For instance, countries have experimented with dual health care systems (public and private) and with vouchers - which could, for instance, be financed by a tax on earnings from "exports" of health services. Equally, exports from a greater inflow of health tourists through the entry of FDI and foreign specialists could generate more opportunities locally which in turn could reduce emigration of skilled personnel - especially if the skills of foreign and domestic personnel are complementary which immigration policy can ensure.

There may also be opportunities to provide greater balance through the contracting of private services on behalf of the population. Work on national health

insurance would also be a key instrument in ensuring equity and re-balancing distribution of financial resources for health and the impact of health tourism would need to be included in the modeling.

3. Regulatory Policy on Standards and Accreditation

In some cases the Ministry of Health has to be given a more strategic role in ensuring the improvement of the health of the population through public health interventions and setting of national policies and standards. Regional agencies that act as regulators by creating standards for industry regionally and internationally should be encouraged. The Nursing Body promotes a common curriculum and regional standards. The Regional Nursing Examination tries to stem the rising trend of temporary emigration of nurses from the Region. The Caribbean Association of Medical Councils (CAMC) is attempting to promote freer movement of physicians throughout the Region by developing a regional examination, promoting registration, licensing, and standards. CAREC, in collaboration with CAST (Caribbean Action for Sustainable Tourism), is implementing a project on Healthy Tourism with the overall goal to improve the quality and competitiveness of the tourism industry. The project purpose or end of project impact will be the establishment and dissemination of quality standards, systems, and registrations designed to ensure healthy, safe and environmentally conscious products.

Regional harmonization could therefore provide a basis for improving local standards and gaining international recognition. Foreign investment can also help overcome one of the biggest obstacles which is the lack of familiarity with the health providers in the region by health tourists and a concern with standards.

Standards of operation for alternative systems of medicine in the country are needed in many countries. The emphasis so far has been on public health standards of the hotel industry so to safeguard the visitors' health. Programmes for developing a framework for monitoring activity or standards or care for this industry are needed.

International accreditation will be key to obtaining medical insurance and medical liability coverage. Even if insurance companies developed products that would allow international coverage in the Caribbean (as Caribbean insurers do now for locals seeking care overseas), the price of that coverage rises with more freedom of choice both in terms of provider and range of services covered. International accreditation will facilitate Caribbean-based facilities to be part of globally recognized networks of a certain quality and to be properly rated for risks. The opportunity will also be provided to broaden the range of services to more aesthetic ones normally outside of any covered insurance package e.g. cosmetic surgery.

The difficulties in obtaining international accreditation are related to the absence of well-established standards, the ad hoc nature of the accreditation procedure, and the high cost of the required improvement in standards. The anticipated increase in tourist flows would justify the required investment in some cases. International accreditation may also not be sufficient to ensure that patients will obtain insurance coverage.

Trade Negotiations in the GATS

CARICOM countries have so far made very limited commitments in the Health sector in the GATS. Their scheduling practices tend to reflect technical and economic specificities of the activities covered. Most of the commitments were concentrated in medical and dental services and hospital services. CARICOM countries generally found it easier to make commitments on health-related professional services (medical and dental services, etc.) than on hospital health and social services. Some CARICOM countries, in particular Jamaica and St Lucia have seen the scheduling process as an opportunity to create, and lock in, stable market conditions with a view to attracting foreign health care providers and, in particular, their skills and expertise.

Countries were careful in undertaking liberal commitments due to lack of experience in services negotiations as well the lack of knowledge of the development consequences of their action. Trade in medical, health and social services is still strongly influenced in the region by other non-trade measures such as licensing and qualification requirements and controls or incentives intended to ensure the equitable provision of services in all regions and for all population groups. The interplay between modes of delivery as already noted in the study provides the basis for liberalization since the entry of FDI (Mode 3) and foreign specialists (Mode 4) could lead to greater exports through Mode 2. Commitments need to reflect greater coherence in this regard.

Objectives in Trade Negotiations in the WTO and FTAA

The GATS is still an uncompleted exercise with significant work in progress. Under the built-in agenda which committed WTO members to at the end of the Uruguay Round to continue services negotiations in the GATS, negotiations got underway in 2000 and a programme of negotiations was elaborated by April 2000. The basic articles of the GATS are yet to be fully elaborated (e.g. safeguards) and the advantages to service providers of WTO Members, although tangible, are limited. The health sector is not one of the most dynamic areas affected by the GATS. Negotiations in health services have not yet been agreed upon. Negotiations are continuing in the area of professional services but these do not currently extend to the health sector. They could be extended if there is a new comprehensive round of Multilateral Trade Negotiations and health services come on the agenda.

Specifically for WTO scheduling purposes in the area of health tourism, CARICOM member states would want to try to more adequately cover the existing and potential activities in this area. As indicated above, at present rehabilitation, wellness programs, spas and cosmetic surgery are some activities that are not properly classified and covered by the categories in the Sectoral Classification List. Further clarification from the WTO Classification Committee is needed as to how some of these services fit into the classification. A more detailed and in-depth classification exercise of health tourism activities is needed as a precondition for further negotiation and one that would make the link between health and tourism activities more specific.

The activities that CARICOM countries would wish to open up in health tourism are mainly those requiring significant inflows in foreign investment as well as the movement of skilled natural persons, the two most important modes. These would be in

the capital- intensive and skill-intensive areas where trade barriers should be reduced or eliminated.

Restrictions on foreign commercial presence in the health sector exist in most CARICOM countries. Only recently some countries have opened to foreign investment in the hope of improving quality and reducing public costs. There is not much evidence that foreign service providers are seeking to invest in the region. The population is small and only a small percentage can afford high-quality and high cost private treatment. Direct foreign investment can act as a spur to a greater influx of health tourists which would be an attractive clientele. Foreign investment can help overcome one of the biggest obstacles which is the lack of familiarity with the health providers in the region by health tourists and a concern with standards.

Domestic regulation will be critical in terms of channeling foreign investment in the specialized areas in which it is needed and avoiding any inequities that could result. For purposes of transparency, it would be useful as well for CARICOM countries to state clearly in the scheduled commitments the conditions under which foreign investment is permitted. Other CARICOM countries besides Jamaica, St Lucia and Guyana, need to revisit their commitments or non-commitments in this sector. Trinidad and Tobago appears extremely restrictive by making no commitments in this area. In certain specialized health tourism areas, especially in the treatment and rehabilitation sectors, CARICOM countries, especially those with a vocation in tourism, may wish to introduce greater liberalization.

Most CARICOM countries oppose the movement of health professionals as from their experience they have incurred a sizeable loss of scarce human resources which impacts negatively on equity, efficiency and quality of healthcare. In recognition of the difficulties of keeping these professionals at home, many countries have introduced more flexible entry requirements to facilitate the inward movement of professionals and take advantage of the current south-south flow of skilled health personnel.

The development of health tourism however, would require some further relaxation of work permits to facilitate attracting the skills particularly in the specialized areas of health tourism as discussed above. Most people think that regulations are sufficiently flexible and operate well on the basis of demand. Applicants for work permits however, always tend to refer to the uncertainty surrounding the process, the cost as well as the long waiting periods in some cases. Trinidad and Tobago has been signaling a change in policy in the health sector by confining the movement of natural persons to just licensing and a qualification test in some well defined areas. The rest of the region may wish to re-examine the current approach to see to what extent greater up-front transparency and commitment could facilitate the acquisition of the needed skilled personnel.

A major trade objective to increase the flow of health tourists to the region by extending insurance coverage and by improving standards. International portability of insurance, recognition of professional and hospital standards should be considered priority areas for discussion and future work. It would be worth considering how the GATS negotiations could be used to make some gains in these areas as a stepping stone for going further in the FTAA.

Caribbean countries may wish therefore, to further examine the possibility of pursuing under Art. VI. 4 the question of standards and portability of insurance as

barriers to trade. Joint ventures with health-care funders to overcome the problem of non-portability of health insurance would also be important. In terms of cross border supply, the main thrust would be in Telemedicine where a new look at e-commerce and telecommunications would have to be taken. Some developing countries are already beginning to provide services in tele-diagnosis.

Trade negotiations in health services in the WTO have been stalled by a reluctance to accept that health care can be traded in the same way as goods and other services. Concern has already been expressed with the unintended implications of trade negotiations in other areas such as government procurement, TRIPS, competition policy, subsidies and investment on health care systems in terms of increasing costs and decreasing equity. Countries are therefore preparing themselves in a comprehensive way and attempting to see the type of domestic legislation that would be needed to preserve universal access to health care. Health tourism needs to be examined in such a broader context in order to draw more conclusive positions.

Health services have not yet come on the Agenda of the FTAA. The NAFTA experience would be instructive in that both MFN and NT are required to be given to cross border services and service providers coming from the other NAFTA countries. However, this duty is subject to a broad right to list service areas which are to be exempted from MFN and NT as a reservation.

The FTAA would represent a huge market in health tourism and the possibilities for increasing the flow of health tourists through the portability of insurance could be enhanced. Already under NAFTA, efforts are underway between Mexico and the US to try and mutually extend insurance coverage to Mexican and US health providers. It may also be possible to achieve agreement on mutual recognition of standards to facilitate the movement of skilled personnel for the desired specialized areas in health tourism. As noted earlier, the Caribbean should examine a long-term strategy for dealing with health standards, accreditation and insurance portability that could begin in the WTO and be extended to the FTAA.

There are, however, some contradictions between free trade and comprehensiveness, universality, and accessibility to health care. Much will depend upon the integrity and broad application of safeguards. As in the GATS as well, a comprehensive approach that touches on investment, government procurement, subsidies, dispute settlement, TRIPS, etc will be needed to ensure a correct balance between equity and efficiency.

TABLE OF CONTENTS

A: INTRODUCTION.....	13
A.1: Objective and Approach.....	13
A.2: Background to Trade in Health Services	15
A.3: Benefits of Trade in Health Services.....	17
A.4: Concerns Associated with Trade in Health Services.....	18
A.4.1: Market Imperfections	18
A.4.2: Crowding out.....	19
B. THE DEVELOPMENT OF HEALTH TOURISM.....	20
B.1. Nature of Health Tourism	20
B.2: Planning for Health Tourism	21
B.2: Barriers to the Development of Trade in Health Services	25
B.3: Experiences with and Opportunities for Trade in Health Services in the English-Speaking Caribbean.....	28
B.3.1: Tourism and Health Services	28
B.3.2: Health Tourism Services	29
B.3.2.1: Convalescent and Elder Care	29
B.3.2.2: Rehabilitation from Drug and Alcohol Dependency.....	30
B.3.2.3: Health Resorts	31
B.3.2.4: Cosmetic Surgery.....	34
B.3.2.5: Telemedicine and Cross-border Trade	34
B.3.2.6: Other health services.....	35
B.3.3 Role of the Private Sector	36
B.3.4: Health Insurance	37
B.3.5: Trade Issues	37
B.3.6: Public Policy and Health Tourism.....	38
B.4: Strategy for Trade in Health Tourism Services in the Caribbean.....	39
B.4.1: A SWOT Analysis	39
B.4.2: A Stakeholder Approach.....	43
B.4.3: Building Blocks and Inputs	46
B.4.4: The role of Foreign Direct Investment (FDI)	47
B.4.5: Social Goals and Free Trade	51
B.4.6: Conclusions and the Plan.....	51
C: TRADE NEGOTIATIONS IN HEALTH TOURISM SERVICES.....	54
C.1. Modes of Trade	54
C.1.1: Movement of Consumers.....	55
C.1.2: Movement of Natural Persons.....	56
C.1.3: Direct Foreign Investment.....	57
C.1.4: Cross-border Supply.....	57
C.2: WTO Classification of Health Services And Health Tourism Activities in The Caribbean	58
C.3: CARICOM Current Commitments under the GATS in the Health Tourism Sub-Sector	64
C.4: Objectives in Trade Negotiations in the WTO and FTAA.....	71
C.4.1: WTO	71
C.4.2: FTAA	75

D. POLICY CONCLUSIONS AND RECOMMENDATIONS	76
D.1 Domestic Policies.....	76
D.1.1 Foreign Direct Investment.....	76
D.1.2. Policies to Ensure Universal Access	77
D.1.3. Regulatory Policy on Standards and Accreditation.....	78
D.2 Key International Policy Issues.....	78
D.3: Strategic Planning for the Sub -Sector	79
D.4: Trade Negotiations	80
D.4.1. WTO	80
D.4.2: FTAA	82

LIST OF TABLES

Table 1: Selected Indicators of Health Care Financing in the Caribbean	16
Table 2: List of products currently being ‘traded’ in the Caribbean by category..	20
Table 3: Characteristics of the Three Categories of Health Services Products...	22
Table 4. SWOT Analysis for Health Tourism Strategy Development	40
TABLE 5. SWOT Analysis for Health Tourism Strategy Development: Benefits and Risks	41
TABLE 6: Specific Modes and Examples of International Trade in Health Services	54
Table 7: Health and Social Services in the GATS Scheduling Guidelines and CPC	58
Table 8: Classification of Health Tourism Activities under Study	60
Table 9: Summary of Specific Commitments on Medical, Health-Related, Social, and Health Insurance Services	64
TABLE 10: Overview of Commitments for Modes 1, 2, 3 and 4 on Medical, Health-Related and Social Services.....	66
Table 11: Health Tourism Services Provided by SERVIMED	102
Table 12: SERVIMED Visitors by Country of Origin (1994)	104

LIST OF FIGURES

FIGURE 1: The Key Players and The Relationships in The Health *	44
Figure 2 Inputs For The Health Tourism Industry	46
Figure 3: Strategic Framework For Expanding Trade in Health Tourism.....	47

LIST OF APPENDICES

APPENDIX 1: SELECTED COUNTRY EXPERIENCES	83
APPENDIX 2. GATS GNS, CPC prov and CPC V1.0	126
APPENDIX 3. COUNTRY VISITS	145
APPENDIX 4. BIBLIOGRAPHY	208

A: INTRODUCTION

A.1: Objective and Approach

According to the general objectives and scope of the study as outlined in the Terms of Reference, “Health Tourism is an activity area in which international demand has been growing and there is interest in developing a strategy to improve the capacity of the (English speaking) Caribbean for sustainable trade activity in this area. The study will involve the examination of the following main components:

- ? Convalescent care and rehabilitation - which includes both clinical activities as well as relationships to health communities;
- ? A health and wellness component, such as use of spas;
- ? Drug and alcohol dependency programs;
- ? Use of local health services by tourists.”

Although the current applicability of Telemedicine in the Caribbean context is in doubt, a possible fifth component was suggested that involved telemedicine-derived activities. The latter could improve the standards of care available in the Caribbean, so encouraging users of the above-referred components to travel to use Caribbean health services and thereby improve the region's competitiveness. Cosmetic surgery was also subsequently added as another component in view of its relevance.

Previous work has pointed to possible competitive strengths in these areas for the region¹. The source of comparative advantage seems to lie in proximity and access to the target markets, relatively strong intellectual capital, an established hospitality industry, and ambient environment. It was not possible to verify the suggested areas of competitiveness with careful quantitative analysis or even some simple international price comparisons of the relative costs of specific services. Eventually there will be a need for the latter.

The main focus of the study will be a combination of developing the industry (in relation to specific segments) and the identification of negotiation objectives and strategy. In terms of output, the main objective is to provide the Regional Negotiating Machinery (RNM) with concrete recommendations as to areas of negotiation pertaining to trade in health tourism and related services for the CARICOM Member States.

Trade in health tourism services is viewed as part of an overall economic development strategy for the Region and specific areas of Health Tourism are underscored in the Terms of Reference. Against the background of the concerns and benefits of trade in Health Services in general, the approach is to examine the

¹ Brenzel and Le Franc, 2000; Gill, 1997; Huff-Rouselle, et al, 1995; PAHO, 1994; Shepard and Vargas, 1994; World Bank. 1995.

development state and the competitiveness of the health tourism industry first, and then to assess the implications for trade policy. The study also aims to identify external barriers to trade in health services for the CARICOM Region, and to determine what can be negotiated with the World Trade Organization (WTO), and eventually the FTAA, to reduce internationally-derived impediments and barriers to trade.

An examination of supply and demand conditions is also undertaken to highlight the growth and consumption trends in each segment and the competitive drivers on the supply side. The existing and potential segments in the Caribbean can then be identified focusing on the supply and demand factors.

The study describes the current situation vis-à-vis trade in health tourism services in the Region, and identifies potential niche markets for trade in health tourism services in the English-speaking Caribbean. In addition, the paper discusses potential regional and country-specific constraints to the development of trade in health services, relating to the current policy framework, human resource availability, and health institutions.

To accomplish the basic objective outlined above, the following specific tasks were requested in the TOR and undertaken:

- ? (a) Introduction and Background, including study objective, a review of the literature on global trade in health services, health tourism, and health and development, trends, tech drivers, health market peculiarities and other relevant aspects;
- ? (b) Presentation of results of country research with special emphasis on Barbados, Bahamas, Trinidad and Tobago, Jamaica, Dominica, and St Lucia, which would provide information and insights regarding the different activity areas investigated in respect of economic importance, supports required, barriers encountered by service delivery mode and any other information deemed relevant;
- ? (c) Provision of enterprise case studies of activities to illustrate major points, for example, Sandy Lane, Le Sport , Crossroads, Health Net in Trinidad, and Hotel de Health in Anguilla.
- ? (d) Examination of cross-cutting issues (including backup services, medical standards, internal barriers, accreditation issues);
- ? (e) An examination of whether the WTO Services classification system caters to the activities covered under this study and recommendations for related reclassification (if required);
- ? (f) An analysis of what RNM countries have scheduled in relation to the sub-sector covered;
- ? (g) Suggestions regarding trade negotiating objectives within the WTO and FTAA, as well as criteria for determining future liberalisation and scheduling in the sub-sector;
- ? (h) Suggestions for the development of the sub-sector.

The following approach was undertaken to accomplish the above tasks:

- Interviews with relevant officials in organizations involved in trade and economic development issues related to health services, such as the Pan American Health Organization, The World Bank, and UNCTAD;
- Site visits, internet searches, and telephone interviews in selected Caribbean countries (Antigua, Bahamas, Barbados, Cuba, Dominica, Jamaica, St. Lucia, and Trinidad and

Tobago) to identify existing examples of trade in health services, and to build country case studies. Site visits also helped to determine potential niche markets and facilitating factors, as well as the major constraints (both internal and external) for trade in health tourism and related services in the Region.

- A review of the relevant literature in health services generally and health tourism specifically.

There is a growing body of literature about trade in Health Services. In Chapter 1, key issues about the Health Market and Trade are highlighted to provide a background for the country situations as it relates to the development of trade in health tourism activity. In Chapter 2, the development of health tourism is examined with country case studies provided so as to bring out common issues that these countries have started to address as well as to highlight the country-specific constraints and problems. These set the stage for moving forward and outlining a strategy. In Chapter 3, the trade negotiation aspect is discussed by examining the modes of supply and the current commitments in the WTO. The latter provides the basis for identifying trade objectives in future WTO and FTAA negotiations.

A.2: Background to Trade in Health Services

Although there is significant investment for health care, the World Health Organization (WHO) recently reports that improvements in health status, coverage and access to care are not equally distributed between and within countries (WHO, 2000). Currently, the OECD countries spend US\$3,000 billion annually on health, which is nearly 90% of total world health expenditure (Wolvaart, 1998; WTO, 1998). Health care spending accounted for at least 8% of GDP in OECD countries, rising to 14% of GDP in the United States (WTO, 1998).

The annual per capita health care expenditure varies widely from US\$3,500 in the U.S. and Switzerland to less than \$5 per capita in sub-Saharan African countries (WTO, 1998). In the Caribbean, per capita health spending is \$239 on average, from \$44 per capita in Guyana, to \$518 per person in the Bahamas. Health spending has generally been on the rise in the region: recurrent health spending increased from 4.2% to 5.8% of GDP in Barbados between 1994 and 1995 (Brenzel and Le Franc, 2000).

Yet, the amount of health spending is not directly correlated with health status, as more health investment does not necessarily mean better health outcomes (World Bank, 1993). For instance, while the U.S. has the highest investment in health among the OECD countries, the country ranks 37 in the world in terms of overall performance of the health sector (WHO, 2000). Countries such as Sri Lanka and Costa Rica appear to have higher returns to health investments than other developing countries (Ibid, 1993).

On the demand side, the rising trend in real spending on health care is related to increases in life expectancy and the aging of the world population, resulting in longer periods required for medical attention. In addition, there has been an increased prevalence of chronic conditions, such as diabetes and hypertension, which are costly to treat. Diseases, such as HIV/AIDS, have a significant impact on health care costs (Brenzel and Le Franc, 2000). In the Caribbean, ministries of health face a dual challenge of caring for patients with chronic diseases, as well as controlling communicable and vector-borne

diseases (PAHO, 1999; IDB, 1996). This task places a financial strain on public health systems.

On the supply side, rising health care expenditures can be attributed to the introduction and indiscriminant use of expensive technologies; insufficient health care planning and coordination; and, lack of incentives to relate the cost of treatment to the expected health benefits. One of the major drivers for rising health care costs is the use of insurance to finance health care. Health insurance effectively separates the patient and the provider from the payment for services, so that there is little incentive to economize on both the use of services, and the intensity of care provided. Patients have a tendency to over-consume care, and providers have a tendency to prescribe a higher volume of diagnostic tests and ineffective procedures. Variable practice patterns by physicians can lead to wastage of health care spending on ineffective or inappropriate treatment by up to 60% (WTO, 1998).

The fiscal constraints faced by governments have led to health sector reform policies and programs, as well as identification with new sources of health care financing. Reform strategies have included organizational restructuring, decentralization, and improved management and administration of the public health care system, as well as concerted resource allocation toward more cost-effective and efficient health care services. The role of government as the primary provider of health care services is changing to one in which there is greater delegation of service delivery to the private sector. Government's role is now focusing more on policy formulation, regulation, and monitoring.

In the search for alternative sources of health care financing, the increased role of the private sector has become tantamount. In many developing countries, the private sector accounts for a growing share of health care spending (Newbrander, ed., 1997; Bennett, et al, 1998). For instance, in the Caribbean, private health care spending is approximately 42% of total health care spending, ranging from 55% in Trinidad and Tobago to 25% in Suriname. (TABLE 1)

Table 1: Selected Indicators of Health Care Financing in the Caribbean

Country	GDP/Capita (US\$ 1995)	National Health Expenditure as a % of GDP	Per Capita National Health Expenditure	Share of Private Financing
Anguilla	\$6,584	5.1%	\$336	47%
Antigua & Barbuda	\$8,110	6.1%	\$496	39%
Bahamas	\$11,940	4.3%	\$518	42%
Barbados	\$6,560	6.4%	\$421	38%
Belize	\$2,696	3.9%	\$106	54%
Dominica	\$2,990	6.6%	\$198	40%
Grenada	\$2,980	5.0%	\$150	47%
Guyana	\$590	7.5%	\$44	31%
Jamaica	\$1,510	5.0%	\$76	51%
Montserrat	\$5,893	6.5%	\$383	37%
St. Kitts & Nevis	\$5,170	5.6%	\$289	43%
St. Lucia	\$3,370	5.0%	\$167	48%
St. Vincent & the	\$2,280	5.5%	\$125	36%

Grenadines				
Suriname	\$1,118	8.0%	\$95	25%
Trinidad & Tobago	\$3,370	4.7%	\$176	55%
Average	\$4,344	5.7%	\$239	42%
Range	\$590 \$11,940	- 3.9% - 8.0%	\$44 - \$518	25% - 55%

Source: PAHO, 1999.

In this era of globalization, another potential source of health financing is through the trade of health services on the international market. While trade in health services is not a recent phenomenon, it is becoming an area of greater strategic importance. For some countries, such as Cuba, Costa Rica, and Singapore, trade in health services is part of an integrated economic development and political strategy. Nevertheless, empirical evidence suggests that the volume of international trade in medical and health services is still relatively modest (WTO, 1998).

A.3: Benefits of Trade in Health Services

While health and social services have long been perceived as non-tradeable services to be provided by the public sector, there has been a change in this policy perception in some countries (WTO, 1998). There are several benefits to trade in health services. First, it is one means of earning much-needed foreign exchange. Revenues from the sale of health and health-related services can be used to a) reduce the trade deficit in developing countries; b) purchase pharmaceuticals and supplies; and, c) import technologies into the health sector.

In theory, resources earned from trade in health services can reduce pressure on public sector financial resources, by either supplementing existing resources, or by substituting public for private resources in health care. Since much of the innovation related to trade in health services depends on private sector entrepreneurship and investment, this can reduce the need for public resources, which can then be used to improve access and quality of public health care services for the local population. In this sense, trade in health services can result in positive redistribution of scarce public health care resources. Domestic consumers also make gains in terms of better access to affordable quality health care.

Trade in health services through foreign investment may have a positive effect on health service delivery, by improving the management, quality, and cost-effectiveness of services. Increased commercial presence in the health sector is thought to lead to increased competition and greater efficiency (Bennett, et al, 1997; Newbrander, 1997), as well as bring in new skills and technology (UNCTAD Secretariat, 1998).

Trade in health services through temporary migration of health personnel can contribute to national income through remittances. In addition, this form of trade facilitates upgrading of health professional skills.

A.4: Concerns Associated with Trade in Health Services

The benefits of trade in health services need to be balanced against potential negative impacts.

A.4.1: Market Imperfections

Trade in health services is likely to be different from trade in other services and trade in commodities for several reasons. One of the fundamental principles underlying free trade is that increased competition will be better for the consumer in terms of lower prices, greater access, higher quality, and efficiency of provision (Bennet, et al, 1997.). This principle stems from the notion of perfect competition which is based on 1) perfect information; 2) large numbers of buyers and sellers; and 3) no barriers to entry and exit in the market. Price is a signal for buyers and sellers to exchange goods and services. However, the market for health services is highly imperfect, so that increased competition in this market will not necessarily lead to improvements in efficiency, equity, or quality.

While there may be many buyers of health services, the number of suppliers is limited. Public health care systems used to be sole providers of medical services in most developing countries, but these systems were immensely bureaucratic and non-responsive to market forces. With the advent of health care reform, private participation in health care delivery and financing is playing a greater role. While one expects private provision of services to be more efficient, access to care may be curtailed because of inability to pay for services. Quality of care may be affected as there are few regulations and controls within the health sector.

There are many barriers to entry and exit in the health care market. Hospitals are expensive to build and operate, so that there will be few investors in developing countries able to raise sufficient capital. Hospitals in both the public and private sectors have tended to operate as if they had monopoly power (Bennett, et al, 1997). Medical associations often control how many and who gets to practice medicine, which limits entry into the market. In some developing countries, however, there is “over-production” of health professionals which tends to distort the structure of human capital formation and boost health care costs (WTO, 1998).

In addition, there is a great deal of uncertainty in the health care marketplace: professionals cannot guarantee a medical outcome, as the effectiveness of treatment is often case-specific. Medical professionals deal with probabilities of outcomes, which implies a certain degree of risk. Consumers often do not have enough information to make informed choices about the best quality and quantity of care. In this context, physicians often act as “agents” for the patient in medical decision-making. In some countries, this phenomenon can lead to escalating costs of care.

Moreover, there is a great deal of asymmetry of information in the health care market between buyer and seller. Patients know their own health status better than insurers, which tends to lead to a condition known as *adverse selection*: sicker individuals tend to join health insurance pools, which eventually drives up the cost of insurance. Higher premiums crowd out certain population groups, leading to additional price distortions in the health insurance market. On the other hand, private health insurers may

“cream skim” by selecting only the healthiest patients in the population, to cut costs and secure profits.

There are a large number of positive and negative externalities in the health care market. An externality is a phenomenon which leads to over- or under-consumption of the socially optimal amount of a good or service. This results in inefficiencies and inequities in the marketplace. A classic example of a positive externality is the benefit that accrues to a group of people with the immunization of one person. As more and more people are immunized against a disease, this act tends to protect the population from outbreaks, so that the un-immunized are protected by the actions of the immunized. In this scenario, there is an incentive for people to remain un-immunized.

Therefore, policy makers need to bear in mind that health services have certain unique characteristics which will affect the quantity of services provided and consumed in the global market place. Changing the incentives of providers and consumers will alter health care seeking behavior, and have implications for free trade.

A.4.2: Crowding out

There is consensus within the Caribbean Region that equity is an important social goal and public health services are an essential input into achieving that objective. Caribbean countries have endeavored to provide good quality health care services, either free of charge or at highly subsidized prices to their populations (Brenzel and Le Franc, 2000). Some policy makers are concerned that by providing health services to visitors, scarce public resources will be reallocated away from much needed public health programs. The local population will not be provided with access to quality health services.

Crowding out can only occur when public funds are used to develop trade in health services. However, government’s role could be to encourage and monitor private sector development of health services that could be traded on the international market. These two tracks for health services can be developed simultaneously, and in a mutually reinforcing way.

B. THE DEVELOPMENT OF HEALTH TOURISM

B.1. Nature of Health Tourism

The recurring question posed in every country is “What is meant by health tourism?” Even for those agencies that have been involved with either promotion or delivery of health tourism activity, there is a growing awareness that there is a lot more to this label and to the development of these ‘products’ – it is not merely an issue of marketing. In the trade context, health tourism in the Caribbean is what people are comfortable talking about - that is the movement of customers into the Caribbean for the consumption of the service in the host country.

Within this mode, a range of ‘health’ services are being provided or traded which for simplicity of discussion can be categorized into three product groups, using the broadest definition of health (rather than medical):

- Wellness/Promotive Care
- Treatment
- Rehabilitation

Table 2 gives the range of products by category that is being considered in the Caribbean as feasible in the short and long term for health tourism, many of which are already being provided to visiting patients.

Table 2: List of products currently being ‘traded’ in the Caribbean by category

Wellness	Treatment	Rehabilitation
<ul style="list-style-type: none"> • Spas • Lifestyle/Healthy vacations • Nature tourism • Ecotourism • Community Tourism • Resorts • Herbal Treatments • Complementary Healing 	<ul style="list-style-type: none"> • Elective surgery • Cosmetic surgery • Joint replacement • Cardiothoracic services • Eye surgery • Diagnostic services • Cancer treatment 	<ul style="list-style-type: none"> • Dialysis • Addiction programmes • Elderly care programmes

Wellness services are being provided primarily through the tourism industry, and clearly demonstrate the capacity of the countries to support the movement of persons for the consumption of services as well as the growing demand particularly for more healthy and active style vacations. These services tend to be the most highly developed aspect of trade in health services in the region both in terms of product definition and marketing. As such, it has begun to attract the interest of health providers, for example in the provision of complementary healing and herbal medicines.

Services in the treatment and rehabilitation categories are being provided primarily through existing health services as an extension of the capacity and interest of the local market. Only a limited number of these services have been developed for the tourist market. Most of the activity is in the private sector, although the public hospitals in Barbados and Trinidad and Tobago are also providing care to non-nationals usually on a government-to-government basis. Facilities have been purposely built to attract foreign patients. Dialysis services in The Bahamas, Jamaica, Anguilla, St Lucia, Barbados represent these types of services which do not on their own merit attract foreign clients but rather facilitate the visit of these clients to the host country.

Treatment and rehabilitation services are usually considered local services used by tourists, and are not strictly considered as part of health tourism. They however, represent a growing and important input for the continued development of the type of tourism that the Caribbean is aiming to attract and retain i.e. a more sophisticated, discerning tourist who expects a certain standard of supporting services, including health, to be available if needed. In addition, the risks associated with eco-tourism and adventure tourism as more active products compared to the sun, sea and surf packages also put additional demands on the quality of health services to manage emergency interventions. The diversification of the tourism product therefore is calling for a more structured approach to the planning of health services as part of the supporting infrastructure that will be required for a sustainable asset based tourism industry.

The main difference between treatment and rehabilitation services is in the acuteness of the condition which in turn affects the length of time needed for direct interaction with a health provider and the range of services needed for the delivery of a quality service. Treatment services for which clients will travel will be characterised by relatively predictable shorter time needed with the provider but a broader, more sophisticated range of services; whereas rehabilitation services usually require a longer time to reach a desired outcome and a narrower spectrum of support services. However, rehabilitation services do require a spectrum of therapeutic support and range of professionals which are in extremely short supply in the Caribbean e.g. physiotherapists, occupational therapists and psychologists. These characteristics are summarized in Table 3. below.

B.2: Planning for Health Tourism

Much of the feasibility of health tourism stems from the growing recognition that health is big business with estimated annual global health-care expenditure in excess of \$3 trillion per annum.² Increasingly the industry is being globalized and the factors that may be contributing to the increasing demand for services outside of the country of origin include:

- increasing costs of services;
- lack of availability of services due to rationing or regulation;
- an upwardly and outwardly mobile client group;

² [UNCTAD-WHO .International Trade in Health Services. A Development Perspective. Geneva, 1998.](#) [Doc. symbol: [UNCTAD/ITCD/TSB/5 - WHO/TFHE/98.1](#)]

Table 3: Characteristics of the Three Categories of Health Services Products

	Wellness Care	Treatment	Rehabilitation
Client group	<ul style="list-style-type: none"> • Upper middle to higher income • Healthy • Low health risk • All ages 	<ul style="list-style-type: none"> • Upper Middle to higher income • Healthy enough to travel • Specific surgical or medical requirements • Variable health risk • Middle age to elderly 	<ul style="list-style-type: none"> • Higher income • Specific needs • Other health conditions • Low to medium health risk • Elderly • Substance abusers
Health services capacity requirements	<ul style="list-style-type: none"> • Good primary care • Growing expectation for hospital services 	<ul style="list-style-type: none"> • Specialist skills • Broad range needed for intervention and backup • Higher level of technology 	<ul style="list-style-type: none"> • Specialist skills • Primary care • More therapeutic intervention rather than medical
Duration	<ul style="list-style-type: none"> • Variable (determined by client) 	<ul style="list-style-type: none"> • Predictable • Shorter • Follow up variable 	<ul style="list-style-type: none"> • Longer • Variable (depending on client)

- technological advances that break down traditional patterns of health seeking behaviour

Movement of clients from less to more sophisticated markets has dominated trade in health services. However, there is no formal collation of data about the movement of persons for health care, either in the country of origin or destination. Further, there is very little routinely-collated information on private health sector activity in the Caribbean so that most of the data are anecdotal and qualitative.

Where it is assumed that the main driver is the lack of those services in the country of origin, other reasons include confidence in local services, confidentiality and privacy, lack of diagnostic capacity and in some cases the service is more accessible in terms of cost and other social barriers in a bigger centre. It should not be taken for granted therefore that investment in better infrastructure, without the upgrading in the quality of staff and management will necessarily result in 'import substitution' or keeping the business in the country.

When planning on a country basis, one approach is to look at population, disease, utilisation, economic and social trends and patterns, and model against international standards of good practice in order to take into consideration impact of new approaches on future needs. Models applied to health tourism could use this data to give an indication of the size of potential markets, but the real questions are:

- What is the source of this data and the relevance (or quality) in terms of estimation of demand for health tourism services?
- What segments of this population with a particular health need are willing and able to seek care outside of their country?
- What are the determining factors to ensure a favourable outcome for the client?
- What level of investment is required in the Caribbean for that outcome and what proportion of that population segment will the Caribbean be able to attract?
- Is this a profitable business in the long term, given the high level of investment required; or is the investment justified for the viability of the tourism industry and therefore should be cross-subsidized by the tourism sector?

Sources of this type of data would be from surveys looking at health seeking behaviour and preferences. However, a fairly large sample size would be required to capture meaningful information about those who sought care or would be willing to seek care outside their own community and country.

Another approach is to examine tourism statistics, but generally the factors that determine the choice of destination for a vacation and the profile of the tourist coming to the Caribbean would be quite different than those for health tourism. Further, the big increase in tourist arrivals in the region in the last 3-4 years has been from cruise ships. The nature of this business is quite different to the stay over arrivals and probably has even less implication for the development of health tourism³. However, tourism trends

³ Some cruise ships advertise the health benefits of this type of tourism. It is known that in some ports cruise ship tourists visit local hospitals, spas and massage shops and indulge in alternative

can indicate how successful the marketing strategy has been in terms of raising the profile of the country and generally the capacity of the country to move people into and around to access services.

In practice, planning in the health market is heavily influenced by supplier-driven and supplier-induced factors. For example, the biggest increase in activity is usually seen when a new specialist or a new piece of equipment (owned by a specialist) is introduced in the marketplace. Although there is much interest in improving the demand side of the equation, the asymmetry of knowledge and the role of the doctor in prescribing the care regime does not easily lend itself to creating an informed and knowledgeable purchaser when it comes to personal medical need. Most of the success in improving how care is purchased has been through the developments in managed care and strengthening of referral networks⁴.

More success has been achieved with increasing consumer knowledge with respect to the healthy lifestyle approach and this trend is manifested in the increasing interest in fitness, health spas, healthy eating, complementary healing, use of natural herbs for medical treatment, healthy active vacations and in a more interventionist way, cosmetic surgery. In addition, the move to sustainable tourism approaches, and an asset-based tourist product development is resulting in an increased level of activity in Eco Tourism and Adventure Tourism as complementary to the traditional sun, surf and sand product. Natural and complementary healing practices are logical adjuncts to these tourism products.

The nature of this demand is clearly demonstrated by the rapid growth of fitness activities in the larger tourist hotels, the increasing number of spa offerings and the increasing networking of smaller hotels with local fitness and sport businesses. The growth in the treatment and rehabilitation categories has been less remarkable, although there seems to be an increasing number of practitioners treating visitors routinely.⁵ The latter service is usually in addition to the normal caseload rather than a specific service developed and targeted to attract tourists. This sense of increased activity is probably therefore a result of the general growth of the private sector and the private sector's interest in looking for populations who can afford to pay for health care.

Many policies and practices do not favour generating business from foreign markets as generally doctors are not allowed by the rules of the profession to actively market themselves or solicit business. The situation is further complicated as most private health facilities in the Caribbean are doctor-owned and managed, the notable exception being Doctors' Hospital in the Bahamas. So whereas there is an increasing number of self-referral for care, most of the business in the health services is based on provider referral and/or recommendation either in the form of formal and informal networks.

medicines. Many of these services are however, provided on board, so that the size of the contribution to the local economy appears to be small.

⁴ It should be noted however, that persons who seek health care abroad may be more highly educated than average and may research different options.

⁵ The use of local health services by Guyanese clients in Trinidad and Tobago is one such example.

In 1995, a World Bank report⁶ on the potential for health tourism in the Caribbean recommended that the Caribbean should focus on developing certain niches and identified the major constraining factors as the poor state of health infrastructure, lack of management capacity and in total costs a relatively high priced service. These constraints meant that the growth of health tourism should be done so as to capitalize on the assets upon which the tourism industry and other services are built i.e. proximity and access to the target markets, relatively strong intellectual capital, an established hospitality industry, and ambient environment.

However, the high unit costs of the health service product (due to our small economies of scale) plus the relatively high priced tourism product preclude the region from being price competitive. It would imply a focus on the development of medical services that compete on quality and on market niches for which the client did not put price as one of the key considerations in the decision making, as for example, cosmetic surgery.

So based on a supplier driven approach to assessing demand for health tourism services in the Caribbean, the emphasis tends to be less on estimating health need and best value for money, but rather more on determining:

- Who are the providers?
- What is their capacity?
- Who is willing to pay for the service?
- Creation and establishment of the product;
- Access to the product through limited direct marketing; and
- Indirect marketing through building of referral networks and a satisfied population.

More action is needed on market surveys in developed markets about health-seeking behaviour to understand why clients would leave their own country and realistically determining if the cost of setting up the service for this client group is justified in terms of the potential return. The main question about south-south trade is the pricing structure of the product and the ability to compete with other developing markets e.g. Cuba, for those clients truly able to pay.

B.2: Barriers to the Development of Trade in Health Services

The literature suggests that there are several barriers to the development of trade in health services in general, and these will likely be applicable to the English-speaking Caribbean as well. In general these are:

- ***Nature of medical practice***: Most health care services are provided on a referral basis with the physician acting as a gatekeeper (Huff-Rouselle, et al, 1995). Practitioners

⁶ World Bank. Prospects for Health Tourism Exports for the English-Speaking Caribbean. World Bank, Washington, D.C. Social Sectors Development Strategies, Inc. September 1995

will not want to lose patients to the Caribbean market, and patients may not be at ease seeking care in unfamiliar surroundings.

The most important barrier to trade is the emotional security of ill persons, in that they will be in unfamiliar surroundings, far from friends and family. Trade in this type of health service will need to overcome this particular barrier through promotion of quality care and access to interpersonal links through telecommunications, and the like (UNCTAD Secretariat, 1998);

- *Laws and regulations*: Clauses contained in laws, regulations and the like, may restrict or block access to the market or discriminate against foreign services or service providers as compared to national ones. The lack of availability of reliable information on government policies and regulations relating to trade in health services represents a significant barrier to trade.

Three types of legislation appear to affect the supply and demand of medical and health services. These include: 1) qualification and licensing requirements for individual health professionals, including paramedical health professionals; 2) approval requirements for institutional suppliers such as clinics and hospitals; and, 3) rules and practices governing reimbursement under mandatory public or private insurance schemes;

- *Financing of care and insurance coverage*: Portability of health insurance represents a significant barrier to free trade in health services. In most cases, private health insurance policies and public systems do not cover treatment abroad, except in the case of emergency (UNCTAD Secretariat, 1998). The portability of health insurance is primarily an issue for the U.S. market, as patients from the UK are covered under national health insurance scheme, and Canada covers all costs of medical care for its citizens. Some European countries offer national health insurance as well.

Americans older than 65 are eligible for a government-sponsored program (Medicare) to cover hospitalization and other medical costs. Entitlement to Medicare is based on age and working status. Medicare does not cover any care received outside of the country. Another U.S. government program, Medicaid, is for the medically indigent population and those suffering from certain illnesses. Medicaid also does not cover care received outside of the country;

- *Accreditation and standards*: Some believe that the English-speaking Caribbean will not be competitive in health tourism in the short term due to real or perceived weaknesses in national health care systems (Huff-Rouselle, et al, 1995). Existing facilities and services cannot provide good quality and reliable back-up necessary for trade in health services. The perception of lower quality services will be difficult to overcome without aggressive marketing and upgrading of facilities.

Given the lack of quality assurance measures, health facility standards, and accreditation of facilities, as well as the difficulty in obtaining malpractice insurance in the Caribbean, it will be difficult for the Region to compete in the area of curative health tourism.

- *Immigration and foreign exchange requirements*: While some countries have changed their immigration legislation to allow for temporary entry of certain categories of health personnel, other restrictions, such as economic needs test requirements; discriminatory licensing procedures; difficulties with accreditation or recognition of foreign professional qualifications; nationality and residency requirements; state and

provincial requirements; access to examinations for completion of qualifications; foreign exchange controls; or discriminatory regulation of fees and expenses, may apply (UNCTAD Secretariat, 1998).

For instance, graduates of foreign medical schools commit to a multi-step process costing upwards of \$US2,500 when they decide to pursue a residency program or fellowship in the U.S. (Employment News, 22 Jan 2001). Interviews conducted for this study suggest that some foreign medical graduates have spent as much as \$10,000 to work in the U.S., largely as a result of legal fees.

Candidates must first obtain certification from the Educational Commission for Foreign Medical Graduates (ECFMG) based on background and credential checks, including the following: 1) copies of medical school diploma ; 2) U.S. Medical Licensing Examinations (USMLE) Step 1 and Step 2; 3) Test of English as a Foreign Language (TOEFL); and, EXFMG Clinical Skills Assessment (CSA).⁷

Once a candidate has met all of the requirements set out by the ECFMG, they must apply for the requisite visa to work in the U.S. as well as they must be matched with a residency program or fellowship. Once a match is obtained, a J1 Clinical Training Visa is issued by the ECFMG. This visa requires that the candidate return to their home country for a period of two years, once the visa period is over (usually 2-3 years). Waivers can be obtained from a U.S. Government agency, though these waivers are extremely difficult and costly to obtain.

- ***Lack of market research on demand for health services:*** Need to increase access to data on demand for health services for potential entrepreneurs and government agencies.
- ***Competition within the Region:*** Several Latin American countries already have well-established health tourism industries. For instance, direct patient care is a major export of Costa Rica, Cuba, Colombia, and Mexico (Huff-Rouselle, et al, 1995; PAHO, 1994). (See for example the Cuban Experience in 2.3)

⁷ To qualify to take the USMLE, each candidate must supply medical diplomas and photographs, and one's school must be listed in the *World Directory of Medical Schools*. Students must take the test within three months of receiving their permit from the National Board of Medical Examiners. The examination costs \$615 for each step, in addition to an international test delivery surcharge. All foreign applicants must take the TOEFL examination, including those persons who are native English speakers. The TOEFL costs \$US110, and is administered in 180 countries around the world. The CSA is given only at one site in Philadelphia, PA, so that candidates who reach this stage must travel to the U.S. to take the exam. Candidates must obtain the requisite visa(s), as well as pay for travel and accommodation in the U.S. The fee for taking the exam is \$US1,200.

B.3: Experiences with and Opportunities for Trade in Health Services in the English-Speaking Caribbean⁸

B.3.1: Tourism and Health Services

Health tourism thrives in islands with an expanding and booming tourism industry and a culture and economy that is geared to looking at tourist markets. The Bahamas is a good case in point where there are a range of health tourism activities associated with the turnaround in tourism in the last few years that has resulted from a surge of FDI. .

By way of comparison, Dominica has been active in developing its tourism industry over the last 10 years recording a significant increase in arrivals in the last 2 years due to cruise ship visitors. The number of stay-over visitors has however, stagnated, and that occupancy rates in many of the hotels (particularly) the smaller ones are not high. Some of the constraints to the development of the stay-over tourism industry in Dominica will also constraint the development of health tourism. The relationship between tourism and health services can also be frustrated where the health services are weak and distant from the tourist resorts as in Jamaica.

The English-speaking Caribbean has many characteristics that could facilitate successful development of health tourism. These include attractive climate and environment; well-trained health practitioners; reliable telecommunications and good transport infrastructure; excellent hotel and tourism services; an educated population; and, lower labor costs than most developed countries (Brenzel and Le Franc, 2000; Huff-Rouselle, et al, 1995; Shepard and Vargas, 1994).

Previous studies have emphasized that the greatest returns in the Caribbean will stem from development of health tourism; health resorts and spas integrating complementary and alternative medicine; cosmetic surgery; rehabilitation; and convalescent care (Brenzel and Le Franc, 2000; Gill, 1997; Huff-Rouselle, et al, 1995; PAHO, 1994; Shepard and Vargas, 1994).

Trade in health services may be more successful with the U.S. market than with the Canadian, European, or South American market because it has a large uninsured and underinsured population, as well as higher prices of medical care. Geographical proximity also makes this market more attractive (Huff-Rouselle, et al, 1995). In Canada, the de-listing of certain services from the national health system may represent some opportunities for health tourism in the Caribbean in the future (Ibid).

However, the competitiveness of the Region's health services will depend upon the price, availability of skilled professionals, service differentiation, and availability of necessary technology and facilities.

⁸ Six countries were selected by the study team to visit and talk to key people who may be active in providing health services to tourists or planning some form of health tourism activity. These countries included Bahamas, Jamaica, Dominica, St Lucia, Barbados and Trinidad and Tobago in geographical order north to south. This section highlights these country experiences with health tourism that either can illustrate progress or relevant lessons. The full country experiences along with a short note on Cuba and a special case in Antigua are presented in APPENDIX 1. The visit reports are available in Appendix 3.

There are several worldwide trends that could possibly generate market opportunities for the English-speaking Caribbean for trade in health services, including the 1) aging of the population and resultant increases in demand for cosmetic surgery, spas, and retirement communities; 2) growing affluence of the younger population, particularly in the U.S.; 3) lifestyles in Europe and North America which put a premium on vacations which can offer spa facilities, fitness, or addiction treatment; and, 4) growth in lifestyle-related illnesses and health problems, such as chronic conditions.

There appears to be a growing interest and activity in the development of spas and complementary healing practices in response to increased demand from the international marketplace. However, much of the development has remained relatively fragmented, small scale with most of the progress in the range of wellness services located in the tourism infrastructure.

B.3.2: Health Tourism Services

B.3.2.1: Convalescent and Elder Care

Convalescent and elder care is one area that is receiving growing attention vis-à-vis trade in health services. This is because of the rapidly aging world population, which is leading to growing numbers of elderly. The senior population accounts for 25.5% of the population of the UK; 20.9% of the U.S. population, and 28.4% of the German population (Smith and Jenner, 1998). The average disposable income of three million retired people in the OECD countries ranges from U.S.\$12,000 to U.S.\$20,000 per year (Wolvaart, 1998).

While some seniors being fairly well-off, and others struggling to live below the poverty line, there is a sizeable senior population that has the ability to finance travel. Seniors (persons older than 50 years of age) accounted 18% of all visits abroad in 1996, and the number of long haul trips has increased to nearly 500,000 in the same year. In the U.S., seniors account for one-fifth of the population, but represent almost half of the long-haul trips. The senior's travel market (aged 55 years or older) exceeds 100 million, and accounts for one in six international trips (Smith and Jenner, 1998).

Persons aged 60 years or older accounted for nearly 10% of total arrivals to the Caribbean in 1998. Forty-six percent of all arrivals were for persons aged 40 years and older (CTO, 1998). In Barbados, senior arrivals have been increasing steadily since 1989, representing 29% of total arrivals in 1998. Senior travelers to the Caribbean represent a niche market that cannot be over-emphasized. Health tourism which is designed around the needs of seniors may be a successful enterprise for the Region.

Prior to major volcanic activity on Montserrat, the island had an expatriate community of nearly 10% of the population.⁹ Approximately 45% of retirees came from Canada, 45% from the northeastern United States, and 10% from the United Kingdom. Most of the retirees were wealthy who wanted the reprieve of life on a tropical island. Residency of retirees created demand for both skilled and unskilled labor, including maids, gardeners, and construction workers. Efforts were made to integrate the retirement community into Montserrat.

⁹ This section draws from Huff-Rouselle, et al, 1995.

Unfortunately, health issues were cited as the primary reason for leaving the retirement community. Retirees felt that the local health system was inadequate for their needs. While payment for health care on Montserrat was not a problem for this population group, those coming from the U.S. were not eligible for health care coverage under their insurance plans.

Other reasons for leaving the island included being far away from family and friends, and financial considerations. Although this population group was wealthy, unexpected changes in the cost of living would affect the cost-effectiveness of staying in Montserrat. Bureaucratic procedures, such as those pertaining to work permits, alien-landholding acts, and visas created disincentives for the community to remain on the island.

Anguilla has considered attracting the retirement community of Montserrat. There are plans to develop a similar community in Dominica over the next few years by Global Medical Health Centers and Resorts.

In Jamaica there are already systems in place to open the market for retirement communities. Jamaicans repatriating after retirement represent a big market for retirement communities but there are many issues now about their safety and absorption back into their communities.

Another impediment to development of convalescent care in the Caribbean is the potential shortage of skilled nursing staff, with the need to import health professionals in the short-run. In the longer-term, retention of Caribbean health professionals may improve due to greater opportunities within the Region (Brenzel and LeFranc, 2000). Growing personal security problems in some countries will inhibit demand for this type of health tourism (Huff-Rouselle, et al, 1995).

Because of the aging population worldwide, the need for health care services for the elderly is rising. There are a few private nursing homes operating in the region which have, on occasion, offered services to visitors. One of these is the Barbados Home Nursing Agency, which began operation in 1982. This facility provides convalescent care for patients coming out of the Queen Elizabeth Hospital. The facility is staffed by trained nurses with physicians on call. The occupancy rate is approximately 70% in this 18 bed facility, though occupancy is seasonal. On average, patients stay three months in the facility, with six months being the maximum length of stay. Financially, the facility is surviving, though there are very tight margins with this type of service, as the cost of labor and benefits are high. It appears that there is room in Barbados for additional facilities, as competition in this domain is not that great.

B.3.2.2: Rehabilitation from Drug and Alcohol Dependency

Drug and alcohol dependency services represent another potential growth area for the Caribbean. Several facilities currently exist in the Caribbean: one of which is highly successful on an international scale.

The Crossroads Centre at Willoughby Bay, Antigua is a non-profit, 36-bed residential facility located on 20 acres in the southeast coast of Antigua, with an excellent view of the sea. The 29-day program, based on the Twelve Steps of Alcoholics

Anonymous (AA) helps clients recover from alcohol and other dependencies. Crossroads is currently rated third in the world¹⁰.

Other rehabilitation services of this type are available in Antigua and the Caribbean. For instance, the Centre refers patients who require a longer program to Mt. St. Benedict in Trinidad. The Turning Point (St. Lucia) and Charter House (Grenada and St. Martin) are both government run facilities in the Region. In addition, the Mount St. John's Medical Centre in Antigua is under development and will be a 187-bed state of the art hospital catering to local and foreign clientele. It is expected that this hospital will provide medical and support back-up to the Centre

The Centre contributes to the local economy through employment of Antiguan nationals as support personnel, administrative and clerical staff, and clinic professionals. Approximately 90% of the materials and supplies used in the Centre are sourced in Antigua, which also contributes to the economy. Because the families of clients utilize tourist facilities, and the Centre hosts alumni reunions of clients and spouses, other sectors in the economy benefit from the operation of this facility. Nevertheless, because some of the inputs and staff come from outside the country, it is difficult to gauge the net foreign exchange contribution.

One of the major drawbacks is that clients cannot claim insurance for the services provided at Crossroads. Recommendations include opening up of international accreditation, and creation of regional bodies to handle accreditation. Because of the specialized nature of rehabilitative services, and the strong competition which exists for clientele, this type of activity may not have the strongest growth potential for the Caribbean. Other issues, such as the perception of the local population towards the clientele, may also prevent widespread growth of this type of health service in the Region.

This case suggests that while the goal was to provide dependency services to the local population, it was necessary to cultivate an international export market first to generate sufficient resources to subsidize patients from the West Indies. This type of model is potentially replicable in the future.

B.3.2.3: Health Resorts

Health resorts and spas are popular in North America and Europe as leisure-time activities, particularly as a result of trends toward healthy living, stress reduction, and spiritual rejuvenation. The Caribbean has a comparative advantage because of the natural beauty and resources of the islands (Crell, 1994). This type of tourism can be linked to resorts and hotels that offer holistic health treatment, such as aromatherapy, yoga, fitness and exercise programs, weight loss and nutrition counseling, and other types of spa treatments. There are few resorts in the Caribbean developed for the purpose of providing stress reduction, and this represents a major potential growth area for Caribbean tourism, given the growing interest in healthy lifestyles and alternative and complementary medicine worldwide (Gill, 1997).

While many hotels in the region have added fitness and day spa services for their clients, there are few resorts in the Caribbean which have been developed solely for the purpose of providing a retreat atmosphere for stress reduction and alternative healing. For

¹⁰ A full description of the work and contribution of the Centre is provided in APPENDIX 1.

instance, analysis of information¹¹ suggests that there are less than 30 full-service health spas operating in the English-speaking CARICOM countries, out of a total of 545 advertisements placed, which is less than 5% of hotels and resorts.

Presently, a number of hotels provide fitness and day spa services, such as facials and massage therapy. La Source in Grenada, Le Sport in St. Lucia, Sandy Lane in Barbados, and most of the Sandals Resorts offer specialized spa and wellness services. In the Bahamas four of the major hotels have spa services and one hotel, the Yoga Retreat on Paradise Island offers a resort package based on complementary healing and a high return visitor rate.

Very few hotels have been designed which incorporate alternative healing in a spa facility. One exception is Sandy Lane Hotel which is being renovated to include a three-story, 45,000 square foot spa facility with 11 VIP suites. Services to be provided include: hydrotherapy, massage, aromatherapy, ayurvedic treatments, thalassotherapy, among others. Spa services will be a la carte in terms of pricing. Therapists will be mainly from Barbados who have undergone an eight-week training session, with continuing training throughout their employment. Physician and physiotherapy services will be available on-call.

Sandy Lane is marketed as a hotel with a spa. They expect their guests to come primarily from the U.K., Europe and the U.S. In fact, they hope the spa will help develop the American market for the hotel. Managers feel there is little competition for their spa services within the Caribbean. The spa is modeled on other international resorts and spas, such as the Oriental Hotel in Bangkok, and is expected to attract this type of clientele.

Because this type of facility is new to Barbados, Sandy Lane has found the government very keen to assist in its development. One drawback has been the superficiality of some of the training courses in massage and aesthetics offered on the island. There is need for upgrading of these courses (to provide basic training in physiology and anatomy, for example), as well as to provide certification. Management believes that licensing and regulation of these types of practitioners will only strengthen this type of tourism product in Barbados.

There are several smaller establishments providing alternative and complementary medicine and healing in Barbados, and a few of them advertise directly to tourists. Examples include the Caribbean Stress Management Institute, St. John; Windward Natural Health, St. James; The Integrated Natural Health Shoppe and Clinic, Hastings; and Reiki School of Natural Healing. In addition, there is a wide range of alternative and complementary practitioners on the island who offer Reiki (e.g., The Barbados Reiki Association; Reiki School of Natural Healing), acupuncture, homeopathy, massage therapy, aromatherapy, and iridology, among others.

Based in Barbados, the Caribbean Association of Complementary and Alternative Medicine (CACAM) is a professional Caribbean association of alternative and complementary practitioners, groups and organizations. The purpose of CACAM is to ensure the integration, acceptance and expansion of alternative and complementary medicine within the health care system through professional and public education; development of practice standards, and advocacy and research.

CACAM supports alternative and complementary medicine practice in the areas of acupuncture/ acupressure, aromatherapy, Chinese medicine, chiropractic medicine,

¹¹ Caribbean Travel (www.caribbeantravel.com)

homeopathy, massage therapy, nutrition, polarity therapy, Reiki, and yoga, among others. The organization was started at the end of 1998, and has approximately 35 members. CACAM hosts a popular annual symposium on alternative and complementary medicine in Barbados.

Alternative and complementary practitioners have trained themselves at their own expense, and represent a tremendous, yet untapped, human resource in the Region. CACAM and its members represent a possible resource for resort operators to tap into in establishing holistic health and spa treatments (Brenzel and Le Franc, 2000).

The World Health Assembly, under WHA 30.49 urges governments to give adequate importance to traditional or alternative systems of medicine (Homer, D. 2000). This policy is in response to growing demand for complementary medicine worldwide, particularly among the U.S. population. Provision of alternative and complementary health services represents a potential niche market for the English-speaking Caribbean.

A recent study found that the proportion of U.S. adults who used at least one alternative therapy increased from 33% to 42% between 1990 and 1997, resulting in a rise from 427 million visits to 629 million visits for alternative therapies per year. Alternative therapies were used most for chronic conditions. This study also found an increase in expenditure from \$14.6 billion to \$21 billion. Insurance coverage did not change over this period, so the increased expenditure comes largely from out-of-pocket (Eisenberg, et al, 1998).

Another study finds that Europeans have a tradition of visiting health resorts and spas. The largest market for health tourism is Germany, followed by Italy and France, particularly for spa treatments and health resorts (Cockrell, 1996). Thalassotherapy (sea water treatment) and thermal resorts have the greatest growth potential in Europe.

With today's growing enthusiasm for health and fitness, spas and health resorts should be able to tap a receptive market of younger, higher income clients who are willing to pay for a holiday that reduces stress and includes pampering. The key will be in marketing services once they have been developed (Cockrell, 1996).

The Ministry of Health in Barbados is aware of the proliferation of paramedical practitioners in Barbados, as well as the growing use of alternative medicine by the Barbadian population and visitors. There is a well-received, call-in radio show hosted by one of the island's alternative practitioners. The Ministry of Health has established the Paramedical Professions Council to establish standards of operation for alternative systems of medicine in the country, and to provide for registration of professions supplementary to the Conventional Medicine (Paramedical Profession Act- Cap 372c). However, there is currently no licensing or registration in operation. Practitioners are interested in legislation which would integrate them more into the mainstream of health care in Barbados (Homer, D., 2000).

Dominica boasts of a strong tradition of herbal medicines and traditional healing practices and lays claim to the oldest living person in the world. Nature tourism and eco tourism have been available in Dominica before it was fashionable and the country is interested in moving forward with that and the marketing of their natural spas – the sulphur springs which traditionally have been known for their healing properties.

B.3.2.4: Cosmetic Surgery

The aging of the population and the growing affluence of some population segments, such as the baby boomers, represent potential market niches for provision of cosmetic surgery. Cosmetic surgery has been provided on Tortola in BVI since the mid-1970s. The market for these services is approximately 50% Caribbean; 40% North American; and 10% from Europe (Huff-Rouselle, et al, 1995). Puerto Rico also offers plastic surgery, but does not appear to be competing in the same market. Other islands, such as Barbados also offer cosmetic surgery to foreign visitors (see Barbados case study). Some services are also provided by Tapion in St Lucia and in Trinidad and Tobago to a clientele primarily from the Caribbean.

A small 12 bed hospital in Lyford Cay in The Bahamas has a cosmetic surgery service geared to tourists, and is considered quite exclusive by virtue of price and reputation. No active marketing is done of the service, which indicates that clients are offered this option by the surgeons involved with Lyford Cay as part of their practice in the USA. There is resident staff in the hospital, and locals are known to go there for routine care. There is one primary cosmetic surgeon on the island who performs breast reduction, liposuction, and abdominal plasty. Patients come from the U.S., the UK, and other Caribbean countries.

Given how tightly regulated the physician market is in Barbados, it is unlikely that this is an area which will be easily expanded in the future

Growing demand for plastic surgery will be a positive factor for trade in this area for the future. However, this type of service can only be successful on a larger scale in the Caribbean if a quality product is provided at a lower cost to the patient. In addition, emergency medical back-up must be available for effective care and treatment. Confidentiality of the services will be an important factor for success.

B.3.2.5: Telemedicine and Cross-border Trade

Within the English-speaking Caribbean, telemedicine has many applications for improving the access of the local population to health care, while at the same time providing continuing education and training opportunities for health professionals (Brenzel and Le Franc, 2000). Currently, there is a relationship between medical practitioners in St. Kitts and Dalhousie University, Canada for radiographic services.

Telemedicine is a computer-based technology, which can assist in providing services which are not locally available, or to treat patients in rural areas through more cost-effective home-base care. The difficulty for the Caribbean in using this technology is related to the cost of establishing and maintaining the system. A centralized telemedicine link costs between \$25,000 to \$50,000, depending upon the type of technology. However, home-based units, which may be ideal for inter-island consultation and communication, cost \$5,000 with a central monitoring facility costing approximately \$7,500. The viability of this option will be improved if a mechanism can be developed within the Region to share the costs and benefits of such a service.

Telemedicine is currently not available in Barbados. The MOH believes this is not a viable option for health tourism as many practitioners and MOH personnel do not have access to computers, nor are they particularly computer literate.

The Caribbean Development Bank (CDB) is working with the private sector to develop the Caribbean Business Enterprise Initiative (CBEI). The purpose of the CBEI is to provide a systematic process for generating business ideas for the global market in order to make the Caribbean more competitive. In addition, it will be a funding mechanism for development of strategic activities related to trade in services. One area under consideration is the growth and development of telemedicine¹².

B.3.2.6: Other health services

Curative health tourism focuses on providing treatment, diagnostic care, or surgical care to patients who travel from their own country. Barbados is able to provide health care services to visitors through its well-developed health sector, comprised of a system of polyclinics, district hospitals, and the Queen Elizabeth Hospital in the public sector, which serves as a referral hospital for the Eastern Caribbean. Approximately 150 private physicians also practice in the country (BAMP, 2000). The private sector also includes private emergency clinics and ambulance services, laboratories and diagnostic services, and a private hospital (Bayview Hospital). Bayview Hospital regularly supplies health services for cruise line passengers through contract arrangements with cruise line operators, such as Goddard Shipping and DaCosta Shipping. In fact, cruise line operators are so confident in the medical services provided in Barbados, that they often hold passengers on ship until they arrive in Barbados for medical attention.

Other health services have developed for use of tourists while on the islands including dialysis services, herbal treatments and the private hospital group, Doctor's Hospital in The Bahamas reports that about 15% of its caseload is geared towards tourists seeking care during their visit. The public sector facilities do not feel that tourists use their facilities to any great extent, as most of their specialists also have private offices outside of either Princess Margaret Hospital or Doctor's hospital.

Since the late 1980s and early 1990s the Government of Trinidad and Tobago had embarked on initiatives to encourage the sharing of health services with neighbouring islands provided by the Eric Williams Medical Sciences Complex (EWMSC). However, EWMSC is still not fully commissioned and therefore has operational constraints in openly marketing itself to the region. It does provide care to individuals from Guyana, Grenada, St Kitts, St Lucia and Barbados on a self referral basis or on a government referral. The link is usually by referring physician.

The operational constraints of EWMSC are related to the ambiguity of the employment status of the staff who work there, and the inability of the government to fund the proper start up of the facility. For EWMSC to be a centre of excellence for hospital services, it must provide a full range of support services including the basic hospital specialties before it can provide in a competitive way tertiary or sub-specialties, which in turn can be marketed on the export market. Much of the referral now is done in

¹² Personal communication from CDB..

the same pattern of utilisation that exists in the private sector throughout the Caribbean, on a piecemeal basis but without the proper support framework if the patient becomes complicated.

EWMSC offers a cardiology service in a joint venture arrangement with a local company who in turn works collaboratively with a European partner. When the programme is started, the cardiothoracic surgeon would come down on a regular basis to do cases that were booked and evaluated by the local team. In recent years, the programme has suffered from the loss of nursing staff for immediate post operative care, so now the visiting team also comprises 1 or 2 cardiac intensive care nurses who remain for about 2-5 days after the operation. Some training is also being provided to local nurses. A similar interventionist service is also being provided in a private hospital in the North with a surgeon from the USA, and there are plans for the construction of a new facility specializing in cardiac treatment.

The Complex has also tried over the years to negotiate a contract with an international partner to set up radiotherapy services as the National Health Plan calls for the transfer of radiotherapy services and the establishment of a cancer treatment centre at Mt Hope. However, this has not been successful because of the lack of the ability of EWMSC to complete the negotiation in time and/or to properly evaluate the international partner. Coincidentally, the North West RHA has negotiated a CT Scan service at Port of Spain General Hospital in a joint venture arrangement with Atlantic Medical.

The private sector anecdotally reports seeing foreign patients on a fairly regular basis, primarily in the sub specialties – ophthalmology, cosmetic surgery, orthopaedics – the majority of which are from Guyana, Grenada and Antigua. Like the foreign patients who go to EWMSC, there is no active marketing being done, but most patients self refer (because of personal reference) or is sent by a referring physician. Most of the private facilities are owned by doctors. EWMSC management speculates that this could be one of the contributing reasons why to date the Complex remains un-commissioned although the doctors would argue that is purely bad design and planning. The MoH collates some data on private sector activity, but is aware that there is a significant level of underreporting and certainly no statistics about treatment of foreign patients.

B.3.3 Role of the Private Sector

In Jamaica the private sector providers have continued on their own to provide and expand where possible their range of services based on information shared on a sense from the workshop of increasing demand in the marketplace. They do not see the equity and affordability issues as their concern and are focused almost exclusively on expanding the local market for their services by attracting the international market.

Distinct from any other private provider in the Caribbean, Doctor's Hospital is actively engaged in providing care to tourists, has embarked on the development of a health insurance product, and is presently commissioning an ambulatory centre and wellness product in affiliation with an internationally recognized fitness agency to specifically target vacationers looking for a fitness oriented holiday complete with medical assessment and support and looking at linking their 3 facilities with telemedicine links. They would be willing to consider extending the network to the family islands and will have a link to the USA.

B.3.4: Health Insurance

Doctor's Hospital has also recognized the need to be internationally accredited to be able to offer its services to the insured American market, and in its 2nd of an estimated 3 year process to become accredited by the Joint Commission for International Health Resources which is a affiliate of the Joint Commission for the Accreditation of Health Facilities in the USA.

B.3.5: Trade Issues

In general, the Ministries of Foreign Affairs and International Trade have not been active participants on any of the recent round of health tourism initiatives. The focus to date has been broadly on intra-regional trade and negotiating liberalization of the CARICOM market and there has been no detailed look at trade in health services specifically.

Broader trade negotiations will have potential effects on trade in health services. As regards the movement of consumers, Governments are keen to look at the management of health risks both in terms of communicable diseases but also if there was risk of decreased access to health care as a result either through an increase in price or loss of local labour.

The movement of professionals is a priority area for liberalization as this would allow easier movement for training and upgrading of skills, but would need to explore incremental liberalization in terms of health as it relates to mutual recognition. Most Caribbean countries import and export health professionals. They have to be careful not to distort the local labour market so there is a need to look at the movement of labour into the country to support these offshore medical centres

Foreign investment contributes to the capacity to manage quality of care for research and experimental care programmes. As a rule, the Caribbean is a less regulated environment than the US and Europe, therefore needs to be affiliated with a reputable programme or facility. The services provided by foreign investors must benefit the local population by stimulating the quality of the local health services.

Island Dialysis is one of the few examples of direct foreign investment in health in Barbados. This facility is operated by the Atlantic Healthcare Group, Inc. out of Ontario, Canada, which also runs similar facilities in Jamaica, St. Lucia, and Puerto Rico. The facility began operation in Barbados two years ago, and employs local staff of four nurses, with two physicians who act as consultants to the facility. While they cater primarily to tourists, they have six local clients. They average approximately 30 clients per month and have 10 dialysis machines. The company advertises its services in several trade magazines, and has a website with links to tourist facilities, information about each Caribbean island, and support services.¹³ Patients are charged \$320 per treatment for a less than three-week period; \$290 for more than a three week period; and \$280 for more than five weeks. A deposit of \$640 is required to secure a dialysis spot.

¹³ The website address is: www.islanddialysis.com

In some countries such as Barbados, the MOH is not formally involved in the application and approval process of foreign direct investment for health services in the country. In Barbados investors interested to develop a health facility or practice can do so without MOH approval, by working through the Chamber of Commerce, the Barbados IDC, and the Office of Economic Affairs.

B.3.6: Public Policy and Health Tourism

In most CARICOM countries, there is presently no government strategy to include trade in health services as part of economic development. The MoH is not actively involved in specific initiatives on health tourism or trade in health services issues. The focus tends to be in the implementation of the Health Sector Reform Programme which aims to improve the quality of health services available to the population and using the strategy of the separation of the government's provider function from its 'purchasing' function.

In Jamaica, for example, MoH's orientation has primarily been on raising the public health standards of the hotel industry and so to safeguard the visitors' health while in Jamaica. The Health Sector Reform Programme has not considered health tourism as a specific issue although developing public-private partnerships falls under the Policy and Planning Division. Ministry of Tourism has been focused on developing the sustainable tourism strategy that could have implications for health tourism.

In Trinidad and Tobago, from the MoH's perspective, work has been ongoing in the Directorate of Quality Management in the development of a quality framework including new legislation, licensing and accreditation issues and establishing mechanisms for monitoring customer satisfaction. The Health Services Act has been drafted to replace the current Hospitals Act and to establish the framework for monitoring quality in all health facilities, including laboratories, diagnostic centres, outpatient clinics and day surgery centres which have been growing in an unregulated fashion to date. Both RHA and private facilities will be governed by this law. Work is also needed to modernize the Public Health Act and for improving professional self regulation. The MoH is also supporting the CAMC initiative for the standardization of medical examinations similar to what has happened for nursing in the Caribbean, so that it will be easier for the movement of CARICOM nationals to work in Trinidad and Tobago.

In Dominica neither the Ministry of Health nor Tourism have embarked on any programme for developing a framework for monitoring activity or standards or care for this industry. While it is felt it must be a good thing to add to the range of tourism products, the issue of consumer protection and liability has not entered the discussion.

In St Lucia the MoH is not actively supporting any activity with respect to health tourism in terms of joint planning with any of the tourism agencies, although it is participating in the CAREC project on improving health standards in the hotel industry through the environmental health team.

B.4: Strategy for Trade in Health Tourism Services in the Caribbean

B.4.1: A SWOT Analysis

Given this sense that there is a demand for health services globally, the interest in health tourism is increasing. The common vision articulated is:

“The customer can come here, get the care they need in a healthy, warm and visitor friendly environment then recuperate in a luxury hotel while following up with the doctor until they are ready to return home – good as new.”

“We have the doctors (either resident or would come back if there was the business) who can provide services to foreign patients either at a lower cost or those services they cannot get in their home country.”

“Providing health services to tourists would expand what is available locally for our own people.”

Table 4 gives a simple SWOT¹⁴ analysis of the Caribbean health sector with respect to the current situation in health tourism. In developing the strategy for the way forward, it is clear that the more important drivers are external to the health sector and perhaps even external to the Region. Ministries of Health are generally not engaged in the trade issues, and private and public agencies involved with trade and tourism lack the understanding about health to make it work. However, the opportunities that are being presented are certainly those outlined for trade in services generally because there is no evidence suggesting that they do not apply to health. The risks, however, of moving ahead without a more structured approach or strategy in place is quite extensive given the imperfections in the health market and the lack of capacity to recognize or manage these risks.

From a trade perspective, the questions that need to be answered are:

- Is health tourism a viable business in itself for CARICOM and if yes, what needs to be negotiated internationally and regionally to allow it to develop in a sustainable fashion?
- Are there aspects of trade in health services that are necessary for the sustainable development of the countries and in particular contribute to the sustainability of the tourism industry?
- What is the implication of the ‘do nothing’ scenario with respect to the globalisation agenda that it happening in the health sector?

¹⁴ Strengths, Weaknesses, Opportunities and Risks

Table 4. SWOT Analysis for Health Tourism Strategy Development

Strengths	Weaknesses
<p>Established tourism infrastructure and capacity to support the movement of customers and the hotel services that would be required to build the market.</p>	<p>Target markets for Caribbean Tourism are the main competitors for health services and health tourism.</p>
<p>Marketing strategies and programmes to promote the Caribbean as a tourism destination from the major northern markets i.e. USA, Canada, UK and Europe.</p>	<p>Caribbean tourism industry is not built on low cost product and on being price competitive, therefore is an expensive add on to the cost of health care - making the overall cost of the health services product (as envisioned) not necessarily price competitive internationally.</p>
<p>Healthy attractive environments for the delivery of products geared to the improvement of health and close to major target markets</p>	<p>Lack of a systematic development of the health sector with weaknesses in infrastructure, management capacity, regulatory capacity and shortages in most health professional groups (particularly nursing and therapists)</p>
<p>Developing health services capacity (public and private) to deliver high quality services.</p>	<p>Small scale of operations in health (due mainly to size of populations) limits range of services available on the islands as well as relatively high unit cost of production and real challenges of keeping skill levels up.</p>
<p>Growing capacity to manage large scale foreign and local investment and development projects.</p>	<p>Ministries of Health inwardly focused with limited capacity for attracting and evaluating investment in the health sector and with limited success generally with HSR initiatives geared at reforming the Central MoH.</p>
<p>Demonstrated capacity and willingness to liberalise markets for trade in services.</p>	<p>Lack of knowledge about the peculiarities of the health market and how to move forward with trade in health services in a sustainable way which is beneficial to the health and well being</p>
<p>Willingness of patients to travel for care.</p>	
<p>Awareness of need for healthy lifestyles.</p>	
<p>Growing private sector in most countries.</p>	

	<p>of all people in the country.</p> <p>Medical insurance portability</p> <p>Malpractice and liability insurance</p>
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TABLE 5. SWOT Analysis for Health Tourism Strategy Development: Benefits and Risks

Opportunities or Potential Benefits	Risks
<ul style="list-style-type: none"> • Foreign exchange earner • Diversifying the economic base of the country so as to minimize dependence on one sector e.g. agriculture and subsequent economic sequelae if that market collapses etc • Moving towards trade in services increases opportunities for value added employment which has positive spin off effects for the quality of development and life in the host nation • Provides opportunities for links to global markets and encourages use of international standards of performance in order to be competitive • Allows institutions to keep up to date with best practice in clinical as well as management areas in a cost effective and efficient manner • Expansion of customer base could make specialist 	<ul style="list-style-type: none"> • Unstructured and unregulated growth of the industry will undermine the quality and access to health care for the poorer communities by contributing to the growing inequity in health • Perceived economic benefit not realized because of the lack of strategies and policies to ensure sustainability of investment and/or the trickle down of financial gain to programmes that will benefit the population (Lessons from the Tourism Industry) • Short term approach can undermine the region's/country's image and reputation if there is a series of failed ventures in health services or if poor outcomes (death or disability) particularly due to negligence results (lessons from the Financial Services Industry) • Malpractice could potentially affect the financial viability of a venture. • Lack of transparency drives away the more ethical investor and provider groups as well as makes the Region more

<p>services more feasible to provide in country and minimize the movement of people and foreign exchange outwards (a form of import substitution)</p>	<p>vulnerable to the less ethical group (medical ethics is important as business ethics in this one)</p> <ul style="list-style-type: none">• Lack of knowledge about the imperfections in the health market at the decision making level makes us prone to approach trade in health services as any other market venture
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B.4.2: A Stakeholder Approach

There are serious lessons to be learnt from the literature and on globalisation and in the Caribbean from the tourism and financial services industries - in terms of government not being able to play their appropriate role in policy, regulation and consumer protection. Whereas it may seem obvious that the private sector is the 'engine of growth' of trade, the Government must provide a stewardship role in ensuring equity, quality, and sustainable development. It is important therefore that the strategy addresses the weaknesses in both the public and private sectors, and aim for balanced development of appropriate structures and instruments suitable to the business of trade in health services.

The lessons from the last decade of globalisation and implications for small developing countries can be applied to the issues of trade in health services. All of the CARICOM countries are considered small developing countries, with only four with populations over 700,000 and the other twelve with populations of less than 300,000 people. Small developing economies differ from other economies in structural characteristics which have implications for the character of the growth process and the capacity for adjustment and include:

- Economic vulnerability because export concentration on a few primary commodities, a high trade/GDP ratio or degree of openness and their small size
- Income volatility due to susceptibility to natural disasters, export instability, higher risk ratings for FDI and constrained adjustment capacity (structural rigidities and institutional weaknesses)
- Lack of international competitiveness due to constraints on material and labour inputs mainly because of the small economy of scale and higher transportation costs which lead to a higher unit production cost.

Small countries can gain from openness if they have the adaptive capacity to adjust and seize the opportunities given the characteristics outlined above. The world economy continues to change at an exponential rate. Those countries that respond to these changes by focusing on protectionist policies are not expected to achieve growth as it is not possible to insulate production or demand from global competition – this is evident in the health sector by the Caribbean's continued loss of critical skilled labour in nursing and medicine. Richard Bernal in his analysis titled "Globalisation and small developing countries"¹⁵ puts forward an argument that small developing economies need to adapt through strategic global positioning, and this analysis applies well to health services.

There is need for proactive adjustment and strategic global repositioning in the Caribbean with respect to trade in health services. Such a strategic response must be holistic and implies profound structural transformation and reform. This will involve development of trade, fiscal and credit policies, supported by education and technology initiatives and close collaboration between the government and the business sectors.

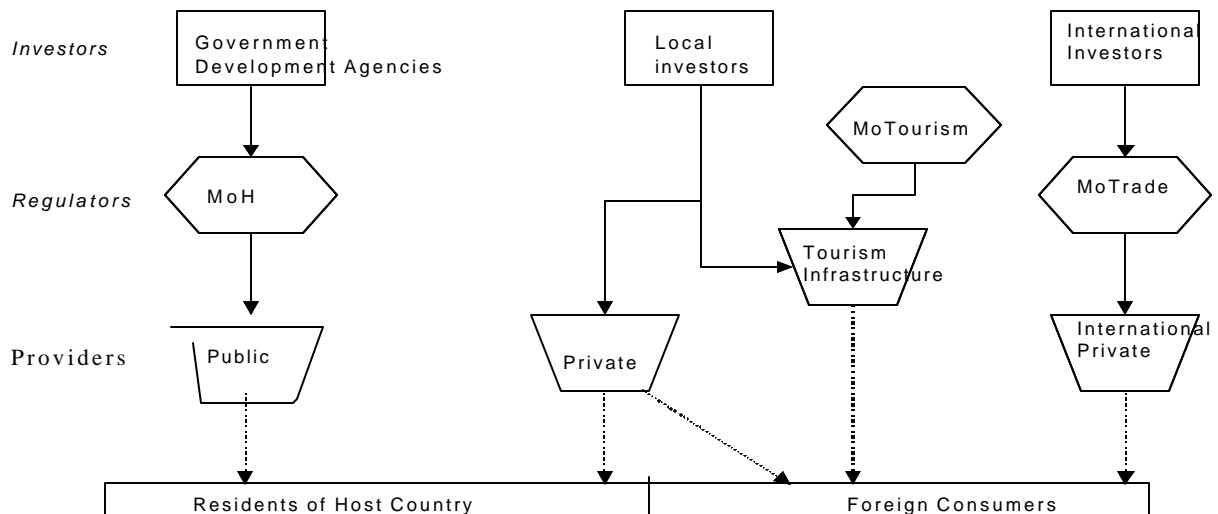
¹⁵ Globalisation: A calculus of inequality: Perspectives from the South Edited by Denis Benin and Kenneth Hall, IRP Publishers Jamaica 2000

Without this strategic approach, it is not likely that the Caribbean will be able to develop world class health providers capable of effectively competing in the global marketplace.

Within this framework, each individual country will have to decide who would lead the development strategy and be accountable for the development objectives being achieved. This is separate and apart from the actual delivery of the services and does not necessarily have to be the same organization. The potential leaders for the strategy include (in no order of preference):

- Ministry of Health
- Ministry of Tourism
- Ministry of Trade
- Development/Investment Authority
- Tourism Development Agency
- Private Sector Agency e.g. Chamber of Commerce, Tourist Board
- Providers – public or private
- Insurance Industry
- Employers
- Joint Task Force/committees

FIGURE 1: The Key Players and The Relationships in the Health Sector*



* A relationship between public providers and foreign consumers exists but is not indicated in the diagram.

Figure 1 illustrates these key players and present relationships and groups them into four broad roles: investors, regulators, providers and customers or clients.

Each country in moving forward will need to complete a stakeholder analysis of or at least evaluate the various interests, resources and potential problems associated with trade in health tourism to determine the most appropriate role for each player in the formulation and implementation of the development strategy.

Figure 1 also attempts to illustrate how the strategy must recognize that the development of activities pertaining to the health tourism industry will both positively and negatively affect the delivery of care for residents of the country (as clients) and this must be a key consideration in moving forward. This is one of the key lessons that is driving the development of sustainable tourism strategies throughout the Region after nearly two decades of tourism development – and, therefore should be critical in moving forward into further commercializing what has traditionally been considered a social sector. Good health status of the people (like environmental conservation) is critical to the sustainable economic development of the country. Current or future generations should not be placed at risk by strategies for maximizing income or foreign exchange.¹⁶

In addition, the intention should not be to draw boundaries around health care for residents and those for tourists. Rather, the aim should be to improve access as well as quality for the local residents as is done now in seeking care in the local private sector and overseas.

In moving forward with the strategy for health tourism, there is a critical need for the further development of cross linkages, at the three levels of investment, regulation (including self regulation) and provision, among:

- sectors (health, tourism, trade);
- public and private;
- national and international.

In the trade and tourism business, this need for promotion and more international focus, led to the development of many of the trade and investment authorities or agencies in the CARICOM e.g. NDC, JAMPRO, TIDCO, BIA to play key roles in marketing and attracting investment. However, many of these agencies now struggle with how to address new sector interests, such as health, and how to affect policy and capacity issues required for implementation of the proposed investment projects. None of these agencies currently have a technical health capacity.

The role of regional agencies involved in trade, tourism and health services will also need to be explored in terms of contributions to common issues of design, development and implementation in collaboration with other national and international agencies and firms. Strengthening of the regional trading of health services (as for instance, the sharing of services as discussed in PAHO) could play a useful role in managed liberalization. Regional agencies can act as regulators by creating standards for industry regionally and internationally, including the negotiation of intra-regional trade policies as they affect trade in health services.

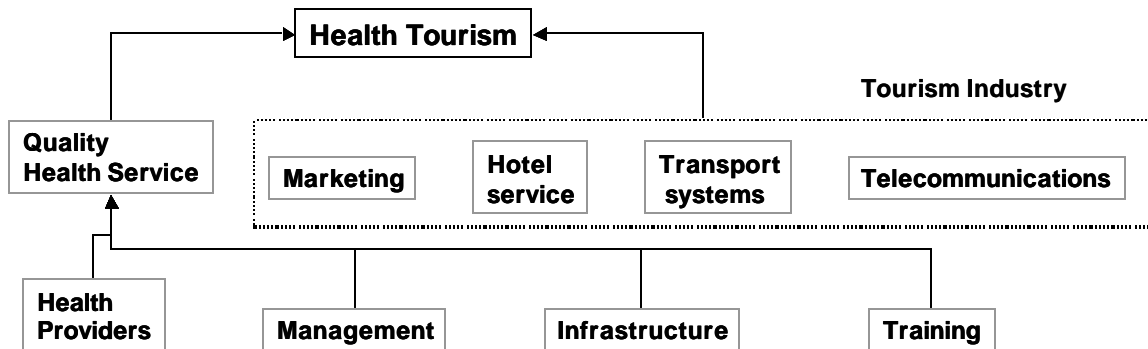
¹⁶ The attention of the authors is drawn to the observation that it may be possible to conceive of a trade-off strategy in which the under-provision of care in the short term to obtain larger economic benefits could lead to universal provision of care in the medium or long-term. Due caution would have to be exercised regarding the feasibility of such an option.

The big question still remains how to proactively and pragmatically engage the private sector within a framework of socially agreed objectives. This implies that government should play a stronger role in regulating, monitoring and involving the private sector in service delivery, particularly in relation to the public health goals. An improved policy and regulatory framework is needed to improve the allocation of resources and equity. There is still a fair amount of duplication of local resources, low returns on investment and inadequate cost-effective customer service. Ultimately, this misallocation of resources in the private sector undermines its efficiency and international competitiveness. It exacerbates the inherent weaknesses of small developing countries as they relate to economies of scale, labour inputs and high production costs. The above strategy therefore must involve leadership that can work across traditional boundaries and relationships to position the industry in a way that creates and contributes to a new paradigm of health care.

B.4.3: Building Blocks and Inputs

Figure 2 illustrates some of the key building blocks for the development of the industry or group of services called health tourism, where it is assumed that tourism development will provide many of the inputs, and that the health service (including complementary healing) will itself require health specific inputs in terms of health providers, management, infrastructure and training.

Figure 2 Inputs For The Health Tourism Industry

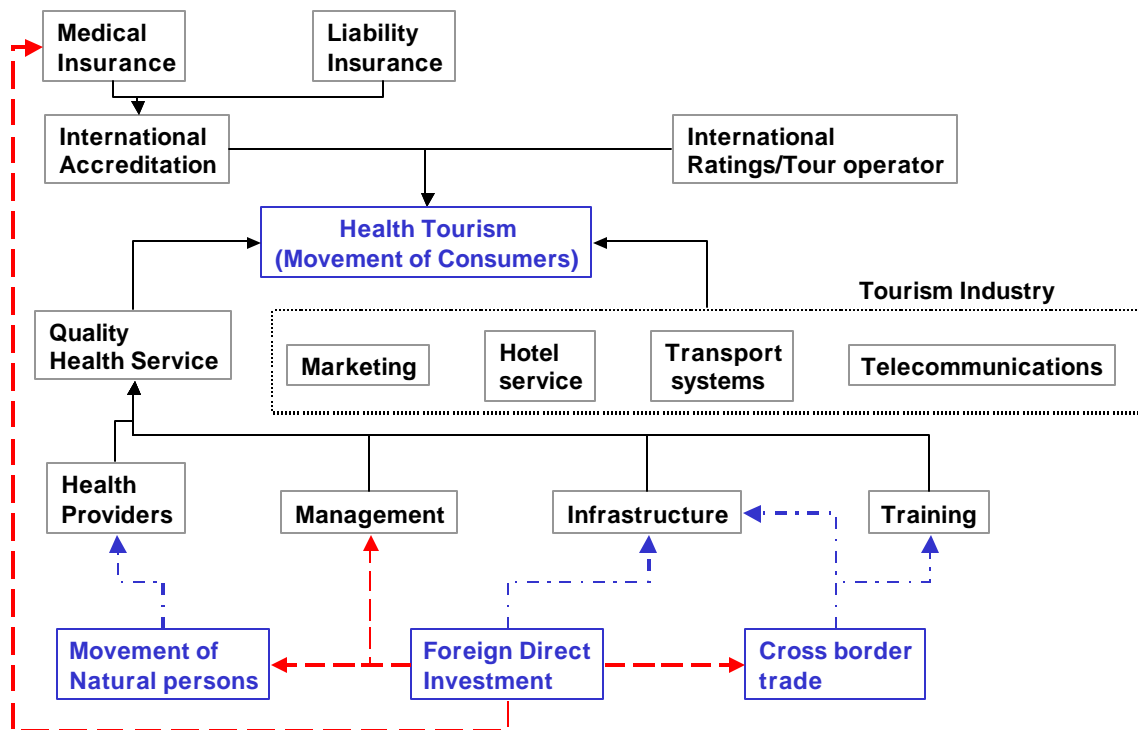


In terms of the trade relationships, the opportunities through the analysis of the various modes outlined in Section C.1 provides an additional development perspective of how trade and globalisation can be enablers to the development of the industry. This is illustrated in Figure 3.

If one views trade in health tourism services as essentially the movement of consumers, then some key demand determinants are shown in Figure 3. Others as shown in Section C.1.1 relate to availability, quality, price, distance and cultural and social factors. The modes, however, are not isolated from each other, and Figure 4. shows possible a strategic trade framework of how aspects of modes 2, 3 and 4 are needed to

implement the strategy for the growth of health tourism in the Caribbean. On the supply side, as shown in Sections C.1.2 and C.1.3 relating to the movement of natural persons and direct foreign investment health professionals from abroad are needed to remove shortages and upgrade skills and foreign investment can provide the capital, management, technology, standards, insurance and quality. These relationships also show how important it is for negotiations in trade in services to take account of the inputs that would be required.

Figure 3: Strategic Framework For Expanding Trade in Health Tourism



B.4.4: The role of Foreign Direct Investment (FDI)

Investment by foreign individuals or companies in the health care arena in a host country is another mode of trade in health services. Foreign investment in the health sector includes facility operation or management. In addition, health insurance companies establishing branch offices overseas represent foreign direct investment. Managed care services, which combine management and insurance into one entity, are another form of trade in the health sector. Many providers of health services have established themselves in foreign countries through joint ventures with local partners.

Foreign investment in the health arena is more prevalent outside of the Caribbean. For instance, sales by U.S. majority-owned health care providers amounted to \$US 469 million in 1995. By the mid 1990s, the Singapore-based Parkway Group Healthcare Pte. had acquired several hospitals in Asia and Britain (WTO, 1998). Some clinics in Canada are trying to exploit the American market (UNCTAD Secretariat, 1998). Given the complexities of the health market that FDI be viewed as more than a source of capital funds - and international partners be sought to provide the management, technical, infrastructure and training inputs required to develop an internationally competitive service. The links to an international network would also help the country to gain access to the export market (through the referral network) and gain accreditation.

International accreditation will be key to obtaining medical insurance and medical liability coverage. Even if insurance companies developed products that would allow international coverage in the Caribbean (as Caribbean insurers do now for locals seeking care overseas), the price of that coverage rises with more freedom of choice both in terms of provider and range of services covered. International accreditation will facilitate Caribbean-based facilities to be part of globally recognized networks of a certain quality and to be properly rated for risks. The opportunity will also be provided to broaden the range of services to more aesthetic ones normally outside of any covered insurance package e.g. cosmetic surgery.

This is not to suggest that one investor needs to provide the whole range of support. It is important that all aspects of this mode of trade be explored in order to address the managerial and technical constraints and weaknesses that presently exist in the health sector, which, in some CARICOM countries, is an even bigger constraint than availability of funds for capital investment¹⁷.

What needs to be encouraged is real public-private partnership on both the capital and recurrent expenditure issues. The key characteristics of investment in the health sector include:

- High level of investment in infrastructure, systems and people;
- Longer time to realize potential profits because of the nature of the product and the imperfections in the market;
- Lower profit margins or return on investment because high social value of the services – gains may not be in the service delivery itself but in downstream products or services;
- Medium to high risk investment requiring tight management throughout the lifetime of the project.

The rapid growth in hotel investment in the Bahamas is related to the large investment in infrastructure. It is also connected to the fact that foreign investors are managing and running the businesses, marketing through the international networks and providing significant amount of training and employment to local residents. This would imply that adequate arrangements for the movement of natural persons are also critical.

¹⁷ Much of the locally available capital is not effectively utilized both in the public and private sector for various reasons, including the lack of regulation and control of introduction of technology and the fact that the public sector plans as if it serves the total population, but in fact does not.

Policy, regulatory, institutional and legislative barriers to foreign investment in health Tourism have been highlighted¹⁸ in the region such as uncertainty and lack of transparency concerning work permits, Alien-Landholding Acts, and visas as well as the absence of information on government policies and regulations pertaining to the export of health care services. The lack of a set of formal regulations readily available to interested investors and governing standards for medical care, licensing, quality assurance and control procedures, clinical practice, and facilities operations has been particularly underscored. Policies regarding the licensing and approval of new technologies, treatments, and drugs were also underscored.

Taxes in relation to the purchase of property and the import of high technology medical equipment were also noted as another deterrent of foreign investment¹⁹. Labor laws are also seen as problematic for expatriates. It is difficult to obtain work permits and the uncertainty of renewal makes many foreigners reluctant to invest. In addition, the legal and regulatory constraints are subject to both interpretation and discretion. Approval times also involve a lot of uncertainty.

While countries are making efforts to eliminate these barriers, the question has been raised as to whether it is sufficient to eliminate barriers or is it also necessary to provide incentives?. The debate on the granting of incentives to correct market failures has raged over the years without any firm conclusions and guidelines. The conditions under which incentives work or do not work are still not known with any precision²⁰.

There is a suggestion that financial incentives matter and are needed in health services.²¹ An examination of incentive legislation in the six countries studied (APPENDIX 1) indicated that none of them offered special financial incentives for the health services industry but Governments in the region have the inherent right to take “off-the-book” decisions to offer special financial incentives. It is often said in the region that no specific incentives are tailored to any sector de jure even though a range of them exists de facto. The design of financial incentives to address the peculiarities of health sector investment is often suggested as a way to stimulate and manage FDI. Governments have however been advised to stay away from sector-specific incentives that tend to distort investment. A more general industry-neutral approach avoids or reduces special pleading. It is non-discriminatory and less distortionary. This tendency to discretionary

¹⁸ World Bank. Prospects for Health Tourism Exports for the English-Speaking Caribbean. World Bank, Washington, D.C. Social Sectors Development Strategies, Inc. September 1995

¹⁹ An alien land holding license can add roughly 10 percent to the cost of land and any purchased buildings. Real estate fees can run as high as 10 percent and there is often a government sales tax that can be 10 percent at the time of sale. Tariffs are levied on medical equipment, spare parts, supplies, and motor vehicles. World Bank, Op Cit.

²⁰ Guisinger, Stephen, “Investment Policies” Mimeo. Presentation to II Academic Colloquium of the Americas. Auditorium “Raúl Prebisch” IDB/INTAL. Buenos Aires, Argentina, April 3-4, 2000.

²¹ According to this Report, CPC toured the Caribbean looking for appropriate sites. CPC decided on Antigua after the government offered a package of financial incentives and agreed to grant work permits and visas to expatriate workers as needed. World Bank, Op Cit.

provision of incentives also leads to foreign firms being given more incentives than local firms. Costly competition among Caribbean countries is also a byproduct which a cooperative efforts over the years have attempted to prevent but with little success²².

In an imperfect world, special incentives never go away, and by far, the greatest competition for investment is among developing countries.²³ The evidence from the Bahamas case study suggests that FDI can make a big difference and is responsive to liberal policies. Bahamas however, offered a range of incentives for hotel investment as laid out in the Hotel Encouragement Act and supporting regulations managed by the Office of the Prime Minister (OPM) through the Bahamas Investment Authority.

In the absence of an agreement among CARICOM countries as well as internationally acceptable conventions to limit unhealthy competition in the granting of incentives, special incentives will continue to stimulate investment in the region. The case of the Bahamas in hotel investment seems to illustrate that in spite of liberal policies to foreign investment that reduced barriers, special incentives were still necessary. The evidence in the health sector is not conclusive enough to suggest that countries could avoid using special sector-specific incentives. Greater emphasis should also be placed on attracting long-term investment as against short-term 'footloose' industries. Lessons learnt from experiences where projects have not achieved the long-term economic objectives but investors have been able to take the short term financial benefits, must be considered seriously in designing the incentive package. The project should be assessed on:

- Clear identification of market demand;
- Technical and managerial capacity to implement the project;
- Financial analysis demonstrating the longer term feasibility of the venture.

In addition, in the health sector, financial investment incentives should be considered as only part of the total incentive package, in that liability and risk management issues could come up long after the investor has reaped the start-up benefits. Again, as history will show in the health sector, it is easy to build the facility but very difficult to run it²⁴.. Incentives also could be developed to encourage joint ventures with

²² The 1974 CARICOM Agreement for the Harmonization of Fiscal Incentives to Industry attempted to contain competition by establishing regulated terms and conditions for granting incentives. Competition however, continued through the granting of non-harmonized incentives at the national scheme. Subsequent proposals were made to revise the Agreement but were not adopted CARICOM Proposals for a harmonized System of Incentives for Industry, Tourism and Other Services and Agriculture Dec. For a list of special incentives given at the national level see Table IX.2 in Caribbean Trade and Investment Report 2000 1993. p.268.CARICOM Secretariat.

²³ Guisinger, Stephen, Op Cit.

²⁴ It is still an open question as to whether performance management contracts should be considered to assess whether certain privileges are retained for the following period e.g. annually, every other year, etc. This is done in the USA so that in order for investors to retain their tax exempt status, they must adhere to certain performance requirements in terms of quality standards or serving poor populations or contributing back to the

local partners. Local partners should clearly demonstrate their contribution to the partnership and a capacity to participate actively in the venture. Care needs to be taken so that incentives do not lead to the creation of local medical cartels.

B.4.5: Social Goals and Free Trade

The question of meeting the social goals in the health sector in the context of freer trade and in a search to increase exports of health services must receive greater priority in national policy making. Liberalization of trade (imports or exports) can lead to changes in the prices of certain goods and services and have an impact on access. This is reflected in the concern about crowding out of poor consumers. There is a feeling that provision of medical services for wealthy tourists may “crowd out” provision of quality health care. This is particularly true when considering the limited number of nurses and doctors and various competing interests in this area. The effect of health tourism may be to aggravate the shift of the labour force away from serving the general public towards more elitist groups (i.e. those able to pay higher prices) and also increasing the demand for more expensive services. The additional costs of establishing services aimed at the tourist market may prohibit development in this area, unless special incentives are given by the government, and foreign investors are prepared to invest in the development of the local health facilities.

The issue really is whether complementary policies can be devised and implemented which ensure that access for the poor is not jeopardized. For instance, countries have experimented with dual health care systems (public and private) and with vouchers - which could, for instance, be financed by a tax on earnings from "exports" of health services. Equally, exports from a greater inflow of health tourists through the entry of FDI and foreign specialists could generate more opportunities locally which in turn could reduce emigration of skilled personnel - especially if the skills of foreign and domestic personnel are complementary which immigration policy can ensure.

There may also be opportunities to provide greater balance through the contracting of private services on behalf of the population, but many of these more highly specialized or esoteric surgeries are limited in the public domain by the simple absence of it, and mechanisms for controlling the introduction of technology (and replication of expensive resources in the private sector to the detriment of quality and sustainability) are not yet in place. Work on national health insurance would also be a key instrument in ensuring equity and re-balancing distribution of financial resources for health and the impact of health tourism would need to be included in the modeling.

B.4.6: Conclusions and the Plan

This strategy differs from current strategies for health sector development in that it begins to take the globalisation agenda into perspective, and the potential for expanding the existing market base beyond conventional country boundaries and local populations. It also differs from strategies for tourism diversification in that it begins to look at the

community. Some believe that it could be a disincentive in the developing world as it could be used in a discretionary and arbitrary way.

implications for the longer term implications of equity in health access, sustainability of the health tourism market and how to ensure that the reputation of the country is safeguarded.

Many of the critical issues being addressed in health sector development and reform programmes are relevant to this strategy and unless resolved, these issues will have a negative impact on the ability to trade in health services in any serious way. The time is opportune for Ministries of Health, many of whom are embarking on sector reform programmes to carefully review the opportunities as well as the responsibilities that health tourism presents.

Some of the shared issues for development include:

- Improving the efficiency of the public sector providers through greater operational autonomy from the MoH;
- Health care financing reform in order to get better value for money being spent by governments and people out of pocket both in the public and private sectors;
- Development of policies and programmes to stimulate private sector activity in providing health care;
- Strengthening of regulatory frameworks (including self regulation) to ensure consumer protection and access to quality care; and
- Transformation of the central MoH to a more strategic role in ensuring the improvement of the health of the population through public health interventions and setting of national policies and standards.

These objectives serve both the development of the health sector and the promotion of health tourism. They would also facilitate foreign direct investment.

In summary, the priority actions or components for the development of the health tourism strategy and plan would include:

1. Establishment of a joint Trade/Tourism/Health mechanism to lead the development and implementation of the strategy covering both public and private sector activity including a communication programme to engage the wider public in the development;
2. Active support of the Health Sector Development/Reform Programmes with particular attention to strengthening the regulatory framework, health care financing reform, planning for new hospital infrastructure and monitoring of private sector activity;
3. Active support to the Sustainable Tourism Strategy initiatives and to review tourism master plans for their implications for use of local health services by tourists and for regulation of the health tourism 'products' being provided in tourism infrastructure;
4. Establishment of an incentive programme for FDI in health sector targeted at health tourism and designed to attract capital flows as well as the supporting links to the export health market, management and training resources;
5. Continued review of trade negotiating requirements both regionally and internationally so as to ensure that CARICOM proactively adjusts to the

changing global environment as it relates to health services and that the health and tourism sectors are aware of the potential impact of these negotiations;

6. The development of complementary policies which ensure that access for the poor is not jeopardized. For instance, countries have experimented with dual health care systems (public and private) and with vouchers - which could, for instance, be financed by a tax on earnings from "exports" of health services. There may also be opportunities to provide greater balance through the contracting of private services on behalf of the population. Work on national health insurance would also be a key instrument in ensuring equity and re-balancing distribution of financial resources for health and the impact of health tourism would need to be included in the modeling.

Countries will need to decide if and how they would like to move forward with this agenda. A project could be designed on a regional basis or a country basis in terms of piloting and sharing lessons. However, it is important that this should be carefully aligned to other regional and national activities or projects so as to avoid duplication of effort and resources for example:

- OECS Trade Policy Project
- CAREC/CAST Project on Health in the Tourism Industry
- ILO Study on sustainable labour practices in the Tourism Industry
- RNM
- CTO initiatives on sustainable tourism strategies
- Sustainable Tourism strategies at national level
- Health Sector Reform Programmes at national level

C: TRADE NEGOTIATIONS IN HEALTH TOURISM SERVICES

C.1. Modes of Trade

The General Agreement on Trade in Services (GATS) is the first multilateral agreement to provide a framework for regulating trade in services with principles similar to those for trade in goods. Health services include both general and specialized services of medical doctors; deliveries and related services; nursing services; physiotherapeutic and paramedical services; all hospital services; ambulance services; residential health facility services; and medical and dental diagnostic services (UNCTAD, 1998).

TABLE 6: Specific Modes and Examples of International Trade in Health Services

Forms of Trade	Modes of Trade in Health Services	Examples
Movement of consumers	Care for foreign patients	Specialized hospital and surgical care, such as transplantation, cosmetic surgery; rehabilitation and convalescent care; alcohol and drug dependency care; traveler's dialysis; health tourism
	Health profession educational services for foreign students	Medical and nursing education provided to foreign students
Movement of providers	Temporary movement of health personnel to provide services abroad	Migration of physicians, nurses, and allied health professionals
	Short-term health consulting assignments	Professional services provided through international agencies, such as PAHO, UNAIDS, etc.
Foreign commercial presence	Establishment of foreign companies, subsidiaries, or foreign investment for the management or provision of health services	Health insurance companies, physician practices, diagnostic facilities
Pure trade across borders	Trade across borders through mail and electronic media; shipment of samples; analysis of information	Shared medical services, telemedicine, laboratory services, claims processing

Adapted from PAHO, 1994, p.12; and Wolvaart, 1998.

The GATS defines trade in health services along four modes of supply, namely: 1) pure trade across borders; 2) movement of consumers; 3) foreign commercial presence; and, 4) movement of natural persons. These four modes of trade can be applied to the health sector. Table 2 illustrates that there are potentially six different forms of

trade in health and health-related services. This study addresses the four main modes, but does not include professional education or examination of short-term consulting services.

C.1.1: Movement of Consumers

Health tourism refers to travel to another country specifically to consume health care services. For this study, health care services are classified into curative and preventive care. Curative care focuses on providing treatment, diagnostic care, or surgical care provided in hospitals, clinics, or private offices by specialists, physicians, nurses, or allied health professionals (PAHO, 1994). Patients undertake purposeful travel to another country to obtain specialized, curative medical services, or obtain emergency medical care while on vacation or traveling. Preventive services include health spas and resorts which offer alternative forms of healing and stress reduction.²⁵

In 1996, U.S. exports of health services amounted to approximately US\$872 million. Patients came from the U.K., Canada, and Mexico. Medical centers, such as the Mayo Clinic and the Massachusetts General Hospital attract significant inflows of patients from abroad (WTO, 1998). Johns Hopkins Medical Center had a rapid increase in the number of foreign patients to 7,200 in 1996 (Wolvaart, 1998).

Patients travel to seek health services for a variety of reasons. The most common reason is related to the lack of availability of a service in one's home country, particularly for experimental procedures or highly specialized care requiring advanced technology or trained personnel. Examples include organ transplantation, cancer treatment, and cardiovascular surgery. For instance, patients travel to Cuba to obtain specialized treatment for vitiligo or psoriasis (PAHO, 1994; Shepard and Vargas, 1994); and India receives patients for organ transplantation.

A second factor contributing to consumption of health care in another country pertains to the cost of health care. If the quality of a particular service is perceived by the patient to be equivalent with that in the home country, patients may be inclined to travel to obtain less expensive care. This may be particularly true for certain procedures that are not covered under health insurance, such as discretionary care (i.e., cosmetic surgery). The uninsured (more than 40 million in the U.S.) may represent a market of individuals which would choose to travel for more affordable health care (Huff-Rouselle, et al, 1995).

In addition to the cost of care, long waiting lists to obtain services (in places like the U.K. and Canada) may prompt patients to travel abroad, and this may be an incentive for seeking good quality health services in the Caribbean (Huff-Rouselle, et al, 1995). Another factor related to movement of consumers is potential anonymity and confidentiality, particularly for treatment of certain diseases, cosmetic surgery, or drug addiction therapy.

²⁵ This distinction has implications for the necessary requirements for development of health service products capable of competing in the marketplace. Curative health tourism requires an adequate health care infrastructure and technology. Preventive health tourism requires less health infrastructure, but greater tourism facilities, and relies on inter-sectoral collaboration.

Cultural reasons may be an incentive for persons residing abroad to travel to seek medical care and health professionals with whom they are comfortable. Patients living along borders between countries may avail themselves of medical services abroad on a regular basis. For instance, households living along the Mexico-U.S. border frequently travel back and forth for medical care (PAHO, 1994).

C.1.2: Movement of Natural Persons

The temporary movement of personnel to provide services abroad is a significant mode of trade in health services. Health professionals migrate to seek improved living and working conditions, and higher pay, often shifting from the public to the private sector (Oulton, 1998). Health professionals may also feel a need to seek professional experience and qualifications elsewhere. The movement of health professionals can temporarily remove shortages in receiving countries, and remittances have a positive effect on countries of origin.

However, developing countries supply 56% of all migrating physicians, but receive less than 11% (UNCTAD Secretariat, 1998). While permanent immigration of health professionals can be detrimental to a country, by resulting in a “brain drain,” temporary movement provides an opportunity for professionals to upgrade their skills.

The Caribbean is a major supplier of the world’s nurses, and approximately 6% of all foreign-trained nurses entering the U.S. are from the Caribbean (Levine and Fox, 1994). Jamaica accounts for the greatest share of nurses from the Region (PAHO, 1994). This has resulted in shortages of experienced nursing staff in the country (Levine, 1992). To rectify the outflows of nurses, Jamaica currently imports them from Myanmar, Nigeria, and Ghana (WTO, 1998).

CARICOM encourages the free movement of health professionals throughout the Region, and there is considerable movement of nurses within the Caribbean. In the early 1990s, the Regional Nursing Body established a regional exam that allows nurses to work anywhere in the CARICOM countries. The Nursing Body promotes a common curriculum and regional standards. One of the goals of the Regional Nursing Examination is to stem the rising trend of temporary emigration of nurses from the Region.

A recent survey showed that for 18 months between 1998 and 2000, 170 nurses (33.5%) remained in the Region, 206 nurses (40.7%) emigrated to the U.K., and approximately 130 nurses (25.8%) went to North America. The study estimated that the Caribbean subsidized recipient countries for training of nurses in the amount of \$14 million (PAHO/CPC, personal communication).

This assessment was thought to show the positive impact of the regional exam vis-à-vis retaining nurses within the region and promoting movement among Caribbean countries. However, another researcher attributes the slowing of migration to the lack of jobs in North America and other parts of the Caribbean (Oulton, 1998).

The Caribbean Association of Medical Councils (CAMC) is attempting to promote freer movement of physicians throughout the Region by developing a regional examination, promoting registration, licensing, and standards. Presently, all non-University of the West Indies (UWI) graduates interested to work in the Caribbean must take the exam. By 2004, it is expected that all medical graduates (from both within and outside of the Caribbean) will be required to take the examination. While one benefit of

this examination is a standardization of medical qualifications within the Region, Medical Boards in the each country will continue to have discretion over who is allowed to practice. This discretionary power has implications for free trade within the Caribbean.

C.1.3: Direct Foreign Investment

There are several benefits to direct foreign investment in the health sector as discussed in Section B.4.4. Opening markets to domestic and foreign competition may contribute to cost reductions in health care, as well as improve the quality of care and range of services provided. However, these results can only occur in an environment where the public and private sectors work together, with the public sector being an effective regulator of the private sector. This is a potential area of weakness for the Caribbean, in that the Ministry of Health is often not involved in decision-making regarding licensing and entry of foreign interests into the health sector.

Some of the barriers to trade relating to foreign direct investment include ownership regulations and economic need limitations. In addition, limits on foreign equity participation can have an effect on the openness of markets to foreign investment.

C.1.4: Cross-border Supply

Cross-border supply refers to the traditional mode of trade between countries. With respect to health services, this includes transfer of information, claims processing, diagnostic services, and telemedicine. The World Health Organization recently noted the increasing importance of cross-border trade in health services, particularly related to sharing of medical information via internet technology. Telemedicine is the practice of medical care using audio, visual, and data communications (Mandil, 1998).

Telemedicine can be used to provide services that are not available locally, such as radiography. In addition, telemedicine can be used to treat patients with chronic disease as part of a more cost-effective, home-based health care strategy. Further, telemedicine can facilitate a second opinion on medical diagnoses and treatment, as well as perform a vital link in the transport and referral of patients from one setting to another. Finally, telemedicine can be used as a training tool to maintain and upgrade the skills of professionals who may not have access to the latest medical information.

Currently, there are few companies that provide travelers with telemedicine facilities. One example is WorldCare International Limited, which began in 1992, and which has affiliates in Asia, Latin America, and the Middle East. This system links travelers to a quality network of highly specialized medical expertise in major medical centers in the U.S. (Morrisey, 1998).²⁶

Some of the potential barriers to trade with respect to telemedicine services include ethical and legal considerations of providing care at a distance, as well as licensure issues for cross-border trade. In addition, most insurance companies do not ordinarily cover services provided through a telemedicine consultation.

²⁶ Expertise is provided by Harvard Medical School, Massachusetts General Hospital, Cleveland Clinic Foundation, Johns Hopkins Medical Center, and Duke University Hospital.

C.2: WTO Classification of Health Services And Health Tourism Activities in The Caribbean

The WTO Services Classification system is based on the GATS Services Sectoral Classification (GNS/W/120) on which Members have based their schedules. Its Sectors and sub-sectors correspond to the provisional Central Product Classification (CPC)²⁷ as outlined in TABLE 7. consisting of a sub-sector of *Business Services* which in turn comprise *Professional Services* (Medical and dental services , veterinary services, and services provided by midwives, nurses, physiotherapists and para-medical personnel) and *Health-related and social services* which cover services other than those listed under professional services above and embrace *Hospital Services, Other Human Health Services, Social Services , and Other*.

The difference between hospital services on the one hand, and dental and medical services on the other, relates to whether the relevant activities include some type of institutional nursing. Hospital services mainly cover activities for in-patients, while services provided by out-patient clinics are considered to fall under Medical or Dental Services. No such difference has been made for veterinary services and social services. All veterinary services, irrespective of where they are provided, are grouped under *Professional Services*. All social services with or without accommodation are classified under “*Health Related and Social Services*”.

Table 7: Health and Social Services in the GATS Scheduling Guidelines and CPC

Sectoral Classification List	Relevant CPC No.	Definition/coverage in provisional CPC
1. <u>BUSINESS SERVICES</u> A. Professional Services [...] h. Medical and dental services	9312	Services chiefly aimed at preventing, diagnosing and treating illness through consultation by individual patients without institutional nursing...
i. Veterinary Services	932	Veterinary services for pet animals and animals other than pets (hospital and non-hospital medical, surgical and dental services).
j. Services provided by midwives, nurses, physio-therapists and paramedical personnel	93191	Services such as supervision during pregnancy and childbirth ... nursing (without admission) care, advice and prevention for patients at home.

²⁷ CPC means Central Product Classification (CPC) numbers as set out in Statistical Office of the United Nations, Statistical Papers, Series M, No. 77, Provisional Central Product Classification, 1.

k. Other ^a	n.a.	n.a.
8. HEALTH RELATED AND SOCIAL SERVICES		
A. Hospital Services	9311	Services delivered under the direction of medical doctors chiefly to in-patients aimed at curing, reactivating and/or maintaining the health status...
B. Other Human Health Services	9319 (other than 93191)	Ambulance Services; Residential health facilities services other than hospital services; Other human health services n.e.c. ^b
C. Social Services	933	Social services with accommodation; ^c social services without accommodation ^d
D. Other	n.a.	n.a.

n.a. Not available

a Relates to all professional services (including sub-sectors (a) to (g)).

b Services in the field of : morphological or chemical pathology, bacteriology, virology, immunology, etc., and services not elsewhere classified, such as blood collection services.

c Welfare services delivered through residential institutions to old persons and the handicapped (PPC 93311) and children and other clients (93312); other social services with accommodation (93319).

d Child day-care services including day-care services for the handicapped (93321); guidance and counselling services n.e.c. related to children (93322); welfare services not delivered through residential institutions (93323); vocational rehabilitation services (excluding services where the education component is predominant) (93324); other social services without accommodation (CPC 93329).

The specific activities in health tourism²⁸ with which there is a concern about classification are as follows:

1. Convalescent care and rehabilitation - which includes both clinical activities as well as relationships to health communities;
2. Health and wellness component, such as use of spas;
3. Drug and alcohol dependency programs;
4. Plastic Surgery;

²⁸ According to the Terms of Reference

5. Use of local health services by tourists;
6. Telemedicine.

Under health-related and social services, the GATS classification is not specific about services and activities aimed at providing specialized medical treatment to tourists. As indicated in Table 2, the category of *Convalescent Care and Rehabilitation* which includes both clinical activities as well as relationships to health communities, can fall under specialized medical services in so far as there is an aspect of medical treatment related to them and some clinical activity. It is also possible to conceive of some of these activities with less medical treatment falling under (CPC 93319)- *Other Social Services*.

Activities relating to a health and wellness component, such as use of spas, in view of their therapeutic nature, can be consider *Professional Services* offered by midwives, nurses, physiotherapists and para-medical personnel provided they involve some medical treatment with a medical doctor located on the premises as some wellness programs do²⁹. Austria specified in its schedule that commitments on CPC 93193 include health resort hotels and therapeutic bath services. This category as shown in Appendix 2 covers services as “*residential health facilities services other than hospital services*” (CPC 93193) as well as combined lodging and medical services not carried out under the supervision of a medical doctor located on the premises.

Drug and alcohol dependency programs with a medical component also would fall under specialized medical services. Some of these programs with less medical content could also fall under “*other social services with accommodation*”.

The classification of plastic and similar types of surgery is somewhat problematic. If such activities contribute to "curing, reactivating and/or maintaining" a patient's health or otherwise be health-related, then they can be classified as medical or hospital. If, however, such activity is mainly for aesthetic purposes, should it still be considered to constitute some form of health or medical treatment and, thus, be captured by CPC 9319 and, consequently, category 8.D in the Sectoral Classification List?. The suggestion has been made that the latter activity could be covered by services as "residential health facilities services other than hospital services" (CPC 93193) as discussed above.

Table 8: Classification of Health Tourism Activities under Study

STUDY ACTIVITY	GATS GNS/W/ 120	CPC prov	Description
1. Convalescent care and rehabilitation - which includes both clinical activities as well as relationships to	1. Business services - A. Professional services-	93122 - Specialized medical services	93122-Diagnosis and treatment services by doctors of medicine of diseases of a specific nature, delivered in a specialists' practice or health institution (including hospital in-/out-patient clinics). These services are defined as those limited to specific or particular conditions, diseases or

²⁹ Specialised programs involving medical treatment include substance abuse rehabilitation and anti-stress therapies.

<p>health communities</p>	<p>h. Medical and dental services 9312</p> <hr/> <p>C. Social services 933</p>	<p>93319 - Other social services with accommodation</p>	<p>anatomical regions (except dental services), such as medical services for the following: nervous system; eye; ear, nose and throat; respiratory system; circulatory system; digestive system; hepatobiliary system and pancreas; musculoskeletal system connected tissues; skin, subcutaneous tissue and breast; endocrine, nutritional and metabolic diseases and disorders; kidney and urinary tract; male reproductive system; female reproductive system; pregnancy, childbirth and puerperium; newborns and other neonates; blood and bloodforming organs; myeloproliferative disorders; infectious and parasitic diseases; mental diseases and disorders; substance use and substance induced organic mental disorders; injuries, poisonings and toxic e</p> <p>-----</p> <p>93319- Social assistance services involving round-the-clock care services by residential institutions, e.g. social work provided by juvenile correction</p>
<p>2. Health and wellness component, such as use of spas</p>	<p>1. Business services A. Professional services -Services provided by midwives, nurses, physiotherapists and paramedical personnel 93191</p>	<p>93191 - Deliveries and related services, nursing services, physiotherapeutic and para-medical services</p> <p>93193- Residential health facilities services other than hospital services</p>	<p>Services such as supervision during pregnancy and childbirth and the supervision of the mother after birth. Services in the field of nursing (without admission) care, advice and prevention for patients at home, the provision of maternity care, children's hygienics, etc. Physiotherapy and para-medical services are services in the field of physiotherapy, ergotherapy, occupational therapy, speech therapy, homeopathy, acupuncture, nutrition instructions, etc.</p>
<p>3. Drug and alcohol dependency programs</p>	<p>1. Business services - A. Professional</p>	<p>93122 - Specialized medical services</p>	<p>93122- As described above.</p>

	<p>nal services-h. Medical and dental services 9312</p> <p>-----</p> <p>C. Social services 933</p>	<p>-----</p> <p>93319 - Other social services with accommodation</p>	<p>-----</p> <p>93319- As described above</p>
4. Cosmetic surgery	<p>Business services - A. Professional services-h. Medical and dental services 9312</p>	<p>93122 - Specialized medical services</p> <p>-----</p>	93122-as described above
5. Use of local health services by tourists	<p>1. Business services - A. Professional services-Medical and dental services 9312</p> <hr/> <p>8. Health related and social</p>	<p>9312:Medical and dental services 93121 - General medical services</p> <p>93122 - Specialized medical services</p> <p>93123 - Dental services</p>	

	services (other than those listed under 1.A.h-j.) A. Hospital services 9311 B. Other human health services 9319 (other than 93191) C. Social services 933 D. Other	----- 931-Human Health Services: 9311 - Hospital services 9312 - Medical and dental services 9319 - Other human health services	
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Since a variety of individual functions can be performed by a doctor, clinic or social institution, it is not surprising that the WTO classification does create some problems. Questions have been raised about the intended coverage of "Other" Health Related and Social Services (category 8.D) in the Sectoral Classification List. Given that the definition of the preceding health and social services categories is non-exhaustive, it is difficult to see the need for a residual group.³⁰ It is also possible that the "other" category under Professional Services (1.A.k.) which is not further specified covers some medical or similar services as well³¹. In addition, there are health tourism activities related to physical fitness facilities, travel clubs and traveller aid societies which are not clearly defined in the WTO classification. In terms of scheduling techniques, there is a need, for the sake of clarity and transparency, to specify the coverage of those "other" categories in the Sectoral Classification List that have no CPC equivalents and do not adequately cover health tourism activities.

³⁰ CPC 9319 covers human health services not elsewhere classified, while 93319 and 93329 are intended to cover "other" social services provided either with or without accommodation.

³¹ WTO. Health and Social Services S/C/W/50 18/8/98

C.3: CARICOM Current Commitments under the GATS in the Health Tourism Sub-Sector

CARICOM countries have so far made very limited commitments in the Health sector in the GATS³². Their scheduling practices tend to reflect technical and economic specificities of the activities covered. In the seven areas discussed in TABLE 9, Jamaica and Trinidad and Tobago have made commitments in three and Belize in two, while the others, Antigua and Barbuda, St Vincent and the Grenadines, Barbados, Guyana and St Lucia have only made commitments in one area.

Table 9: Summary of Specific Commitments on Medical, Health-Related, Social, and Health Insurance Services

Members	Professional Services			Health-Related and Social Services			
	Medical and Dental Services	Veterinary Services	Nurses, Midwives etc.	Hospital Services	Other Human Health Services	Social Services	Other
Antigua and Barbuda	x						
Barbados	x						
Belize	x				x		
Guyana	x						
Jamaica	x		x	x			
Saint Lucia				x			
Saint Vincent and the Grenadines				x			
Trinidad and Tobago	x	x		x			
TOTAL							

Source: WTO Secretariat

Most of the commitments were concentrated in medical and dental services and hospital services. Of the four countries (Trinidad and Tobago, Jamaica, St Vincent and the Grenadines and St Lucia) that made commitments in hospital services, Jamaica and St Lucia made full commitments in the first three modes- cross-border supply, consumption abroad and commercial presence. Trinidad and Tobago and St Vincent and the Grenadines made full commitments on the first two but respectively made no

³² Schedules do not necessarily give an accurate account of actual trade and market conditions. This means that, in the absence of additional information, non-commitments (or the scheduling of strict limitations) cannot be equated with limited or non-existent access opportunities.

commitments and limited commitments on mode 3 commercial presence. On mode 4, Trinidad and Tobago was the only country to accept full commitments.

Six countries made commitments in medical and dental services: Guyana, Jamaica, Trinidad and Tobago, Antigua and Barbuda, Belize and Barbados. Guyana was the only country to make commitments in both medical and dental services.

Jamaica and Antigua and Barbuda restricted themselves to Medical Services while Barbados committed itself just to specialized medical services, Belize to General Medical Services and Trinidad and Tobago to Dental Services. Belize, Guyana and Jamaica made full commitments in the first three modes with Barbados and Antigua and Barbuda making limited commitments in Mode 3 and Trinidad and Tobago making no commitments on Mode 3. Foreign service providers can supply services to the local market in Jamaica, Guyana and Belize as indicated through the establishment of facilities. This however, is subject to a work permit as well as involves licensing or registration, membership of the relevant professional association and possibly other requirements. Trinidad and Tobago made full commitments on Mode 4 with respect to Dental Services.

In the other areas, Trinidad and Tobago made full commitments in the first two modes in Veterinary Services but no commitments on Mode 3 and full commitments on Mode 4. In services of midwives, nurses, etc, Jamaica made full commitments on the first three modes. It was the only country to make commitments on services provided by medical personnel other than medical or dental doctors. The other countries with well established competitive strength in nursing services made no such commitments. In Other Human Health Services, Belize was the only country to make commitments in Epidemiological Services. Most entries with regard to mode 4 simply extend existing horizontal commitments and restrictions.

CARICOM countries generally found it easier to make commitments on health-related professional services (medical and dental services, etc.) than on hospital health and social services classified as Sector 8 in the Sectoral Classification List. Six Members have undertaken commitments on Medical and Dental Services as compared to four Members that committed on Hospital Services. Moreover, similar to the general pattern worldwide, it is interesting to note that within the two broad groups of medical and health-related services, the level of commitments seems to be positively related to the capital and/or human-capital intensity of the activities concerned. Medical and Dental Services as well as Hospital Services have drawn significantly more commitments than, for example, Services Provided by Midwives, Nurses etc. (CPC 93191) or Social Services (CPC 933).

Some CARICOM countries, in particular Jamaica and St Lucia have seen the scheduling process as an opportunity to create, and lock in, stable market conditions with a view to attracting foreign health care providers and, in particular, their skills and expertise.

TABLE 10: Overview of Commitments for Modes 1, 2, 3 and 4 on Medical, Health-Related and Social Services

Sector	Full commitment for Modes 1-3 ^a	Cross border supply (Mode 1)			Consumption abroad (Mode 2)			Commercial presence (Mode 3)			Movement of natural Persons (Mode 4)		
		Full ^a	Limited	Unbound	Full ^a	Limited	Unbound	Full ^a	Limited	Unbound	Full ^a	Limited	Unbound
Hospital Services³³ (CPC 9311)													
Jamaica	*	*			*			*				*	
St Vincent		*			*				*			*	
St Lucia	*	*			*			*				*	
Trinidad and Tobago		*			*					*	*		
Other Human Health Services: (CPC 9319)													
	*	*			*			*				*	

³³ In the United Nations Provisional Central Product Classification, CPC 9311 - Hospital Services - is defined as covering "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. Hospital services comprise medical and paramedical services, nursing services, laboratory and technical services including radiological and anaesthesiological services, etc.". It may be worth noting that this definition does not require the simultaneous physical presence of both doctor and patient.

Belize ?													
Medical and Dental Services (CPC 93121, 93122)													
Antigua and Barbuda ?		*			*				*				*?
Barbados ?				*			*		*				*
Belize ?	*	*			*			*					*?
Guyana	*	*			*			*					*
Jamaica ☒	*	*			*			*					*
Trinidad and Tobago?		*			*					*	*		
Veterinary Services (CPC 932)													
Trinidad and Tobago		*			*					*	*		
Midwives, Nurses, etc.(CPC 93191)													
Jamaica	*	*			*			*					*

- ? Dental Services only. (CPC 9312)
- ? General Medical Services (CPC 93121), Neuro-surgery, Epidemiological services, CATSCAN series
- ? Unbound in National in Treatment Mode 4.
- ? Medical services (CPC 93122 - specialized medical services)
- | Unbound in National Treatment in Mode 4.
- ? Epidemiological Services
- ☒ Medical services (CPC 93121, 93122)

- ? Medical services (CPC 9312)
 - ? Unbound in National Treatment in Mode 4.
 - a Full commitments for both market access and national treatment and no limitations in sectoral coverage.
- Source: WTO Secretariat.

In terms of the activities under study, both Convalescent Care and Rehabilitation as well as Drug and Alcoholic Dependency Programs are covered by 93122 to some extent. The countries that have made commitments in this area are Antigua, Jamaica, Barbados and Guyana. Jamaica and Guyana in particular have made full commitments on the first three modes. Barbados made no commitments on Modes 1 and 2 and limited commitments on Mode 3 as compared to Antigua which have made full commitments on Modes 1 and 2 but limited commitments on Mode 3. All have limited horizontal commitments on Mode 4.

As regards Health and Wellness Services including spas, as covered by 93191, Jamaica is the only country that has made commitments here and fairly liberal ones in the first three modes. No country did like Austria and covered spas in 93193-Residential Health Facilities Services Other than Hospital Services. Concerning Cosmetic Surgery, this would be covered by specialized medical services but as noted earlier there could be an aspect related to aesthetics not covered. Finally in terms of the use of local hospital services by tourists, Jamaica, Trinidad and Tobago, St Lucia and St Vincent and the Grenadines have made commitments with Jamaica and St Lucia allowing for easier entry of foreign investment in local hospitals.

It is of interest to note that in spite of the uncertainty surrounding cross-border tradability under Mode 1, all 4 countries that have committed on Hospital Services, have undertaken full bindings for Mode 1 ("none"). This is against the general trend of WTO commitments in this area where the majority of countries have not undertaken any commitments ("unbound")³⁴ in this area with a sizeable number believing that cross-border supply was not technically feasible.³⁵

All the countries with the exception of Barbados have made full commitments on consumption abroad (Mode 2) of the medical, health and dental services. Generally, therefore, governments did not attempt to constrain their nationals' ability to consume such services abroad. This would be in recognition of the need to find specialized medical services outside the region as well as a "safety valve" in systems that cannot ensure immediate treatment domestically and subject patients to a long waiting list.

Limitations on market access and/or national treatment are found under Mode 3, commercial presence. This applies to Medical and Dental Services and Hospital Services. The limitations are intended to provide cover, *inter alia*, for economic needs tests intended to contain health costs, nationality requirements, equity ceilings, joint venture requirements and further specified licensing and approval procedures. More cautious treatment is found in market access than under national treatment.

The level of mode-4 commitments, governing the presence of national persons, falls far behind the commitments undertaken for the three other modes. With the exception of Trinidad and Tobago in some areas, countries have not undertaken any commitments for that mode. They have maintained horizontal limitations, without further narrowing these horizontal commitments

³⁴ According to WTO. Health and Social Services, Op Cit. "Members are called upon to use such entries (i.e. "unbound due to lack of technical feasibility") whenever relevant. In the event of misjudgement or future technical change, these entries continue to mean "unbound". If a Member had failed to commit because of a misperception of what is technically possible, its schedule would look more restrictive than it was intended to be."³⁴

³⁵ It has been suggested that to improve clarity and comparability of schedules, it would be helpful to develop a common understanding among Members of the activities and circumstances in which trade is not technically feasible.

and have not added nationality and/or residency requirements. For many medical, health and social services, Mode 4 restrictions are particularly significant since the most significant benefits from trade are unlikely to arise from the construction and operation of hospitals, etc., but their staffing with more skilled, more efficient and/or less costly personnel that might not be available on the domestic labour market.

No MFN exemptions were listed by CARICOM members to the four categories or to individual health and social services except Jamaica for the work permit requirement which will be waived for citizens of the CARICOM countries. Jamaica intended in its horizontal commitment to provide legal cover for the reciprocity requirement governing market access for professionals under the Single Market and Economy.

In conclusion, countries were careful in undertaking liberal commitments due to lack of experience in services negotiations as well the lack of knowledge of the development consequences of their action. Trade in medical, health and social services is still strongly influenced in the region by other non-trade measures such as licensing and qualification requirements and controls or incentives intended to ensure the equitable provision of services in all regions and for all population groups. The interplay between modes of delivery as already noted in the study provides the basis for liberalization since the entry of FDI (Mode 3) and foreign specialists (Mode 4) could lead to greater exports through Mode 2. Commitments need to reflect greater coherence in this regard.

C.4: Objectives in Trade Negotiations in the WTO and FTAA

C.4.1: WTO

The Agreement on Trade in Services (GATS) was adopted in order to protect cross border trade in services from discriminatory measures which restrain or frustrate the ability of service providers to offer their services in other countries. The question for the health sector in the region is to determine whether the potential advantages of the extension of service protections to health services would be of sufficient benefit to CARICOM health providers at home and abroad to justify the probable disruption to the existing domestic health system. In order to benefit from exports of health services in the long run CARICOM may be forced to open at least some of its health service markets. This is thus first and foremost a matter of national development policy for the region.

Under the GATS WTO Members must grant MFN treatment to the cross border services of all Members if they grant them to any one Member. MFN is subject to a further right to refuse MFN treatment in areas chosen by the WTO Member State. The result of this is that MFN treatment may not apply to many service areas if foreign service providers are not allowed into the country. In the field of health care, CARICOM has allowed few foreign health providers into the region so that it owes little MFN treatment in the sector.

National treatment (NT) under the GATS is not generally granted as it is under the GATT to goods. Rather, it is only available to those services where a WTO Member specifically offers it in its schedule of NT concessions. CARICOM countries have made some NT concessions in the area of health services.

The GATS is still an uncompleted exercise with significant work in progress. Under the built-in agenda which committed WTO members to at the end of the Uruguay Round to continue services negotiations in the GATS, negotiations got underway in 2000 and a programme of negotiations was elaborated by April 2000.

The basic articles of the GATS are yet to be fully elaborated (e.g. safeguards) and the advantages to service providers of WTO Members, although tangible, are limited. The health sector is not one of the most dynamic areas affected by the GATS. Negotiations in health services have not yet been agreed upon. Negotiations are continuing in the area of professional services but these do not currently extend to the health sector. They could be extended if there is a new comprehensive round of Multilateral Trade Negotiations and health services come on the agenda. The EC and the United States have been pressing for further negotiations on services.

The GATS extends trade rules into areas of domestic policy. It covers government measures related to investment as well as trade as well as non-tariff barriers to trade in services. Are there grounds to fear that these negotiations will lead to a reduction in the ability to regulate how health services are provided in the region?

One major concern has been the greater role being accorded to foreign investment and the privatization of health care services. It is feared that in the sweeping negotiations to extend the reach of GATS rules, compromises will be made that will include a commitment to provide the same level of treatment to all foreign investors. All countries are committed to increase the coverage of the national treatment and market access rules. Some countries are already committed to broader coverage of their own health services and are expected to press hard for further coverage of the health services of other countries.

CARICOM trade negotiators, conscious of the political sensitivity of making specific commitments in certain areas, need to devise approaches which could extend coverage of health services without necessarily disrupting the development and equity aspects.

As well as extending the coverage of existing rules, GATS negotiations are required to develop new trade rules affecting domestic regulation that would have broad implications for health services. Health measures that could be covered range from qualifications required for accreditation and certification of health professionals, to licensing of hospitals, health clinics and other facilities, to performance standards and codes of ethics for health practitioners. CARICOM countries are pursuing the widely recognized objectives of equitable access to health care, efficiency in terms of the allocation of resources and quality in health care in terms of standards. Trade can have positive and negative impacts on these objectives

Specifically for WTO scheduling purposes in the area of health tourism, CARICOM member states would want to try to more adequately cover the existing and potential activities in this area. As indicated above, at present rehabilitation, wellness programs, spas and cosmetic surgery are some activities that are not properly classified and covered by the categories in the Sectoral Classification List. Further clarification from the WTO Classification Committee is needed as to how some of these services fit into the classification. A more detailed and in-depth classification exercise of health tourism activities is needed as a precondition for further negotiation and one that would make the link between health and tourism activities more specific.

The activities that CARICOM countries would wish to open up in health tourism are mainly those requiring significant inflows in foreign investment as well as the movement of skilled natural persons, the two most important modes. These would be in the capital-intensive and skill-intensive areas where trade barriers should be reduced or eliminated.

Restrictions on foreign commercial presence in the health sector exist in most CARICOM countries. Only recently some countries have opened to foreign investment in the hope of improving quality and reducing public costs. There is not much evidence that foreign service providers are seeking to invest in the region. The population is small and only a small percentage can afford high-quality and high cost private treatment. Direct foreign investment can act as a spur to a greater influx of health tourists which would be an attractive clientele. Foreign investment can help overcome one of the biggest obstacles which is the lack of familiarity with the health providers in the region by health tourists and a concern with standards.

Domestic regulation will be critical in terms of channeling foreign investment in the specialized areas in which it is needed and avoiding any inequities that could result. For purposes of transparency, it would be useful as well for CARICOM countries to state clearly in the scheduled commitments the conditions under which foreign investment is permitted. Other CARICOM countries besides Jamaica, St Lucia and Guyana, need to revisit their commitments or non-commitments in this sector. Trinidad and Tobago appears extremely restrictive by making no commitments in this area. In certain specialized health tourism areas, especially in the treatment and rehabilitation sectors, CARICOM countries, especially those with a vocation in tourism, may wish to introduce greater liberalization.

Most CARICOM countries oppose the movement of health professionals as from their experience they have incurred a sizeable loss of scarce human resources which impacts negatively on equity, efficiency and quality of healthcare. In recognition of the difficulties of keeping these professionals at home, many countries have introduced more flexible entry requirements to facilitate the inward movement of professionals and take advantage of the current south-south flow of skilled health personnel.

The development of health tourism however, would require some further relaxation of work permits to facilitate attracting the skills particularly in the specialized areas of health tourism as discussed above. Most people think that regulations are sufficiently flexible and operate well on the basis of demand. Applicants for work permits however, always tend to refer to the uncertainty surrounding the process, the cost as well as the long waiting periods in some cases. Trinidad and Tobago has been signaling a change in policy in the health sector by confining the movement of natural persons to just licensing and a qualification test in some well defined areas. The rest of the region may wish to re-examine the current approach to see to what extent greater up-front transparency and commitment could facilitate the acquisition of the needed skilled personnel.

Modes 1 and 2 are not as binding as Modes 3 and 4. Already significant commitments have been made in these modes. A major trade objective under Mode 2 is to increase the flow of health tourists to the region by extending insurance coverage and by improving standards. The portability of insurance and standards are therefore key issues for trade negotiations. As noted in the WTO study "recognition measures applying

to foreign licences, qualifications or standards (including for medical and hospital treatment) may determine the economic value of commitments under the GATS. Such measures could affect insurance portability (thus determining the ability of patients to consume foreign hospital services) or the possibility for professionals of working abroad without undergoing additional tests and examinations³⁶. The study further notes that "recognition measures may gain prominence in future as the gradual opening of health insurance and health care markets in certain regions, such as Latin America, tends to enhance the regulatory conditions for trade, including via improved cross-border mobility of patients"³⁷ As noted above, already under NAFTA, efforts are underway between Mexico and the US to mutually extend insurance coverage as well as achieve agreement on mutual recognition of standards to facilitate the movement of skilled personnel for the desired specialized areas in health services. International portability of insurance, recognition of professional and hospital standards should be considered priority areas for discussion and future work. It would be worth considering how the GATS negotiations could be used to make some gains in these areas as a stepping stone for going further in the FTAA.

As far as the GATS is concerned, the question has been raised as to whether issues of standards and the portability of insurance can be raised under Article VI in GATS. Paragraph 4 of Article VI of the GATS calls upon the Council for Trade in Services to develop any disciplines necessary to ensure that measures relating to qualification requirements and procedures, technical standards and licensing requirements and procedures do not constitute unnecessary barriers to trade in services. The Working Party on Professional Services has already examined the main issues concerning the relevance of the Agreements on Technical Barriers to Trade (TBT) and Import Licensing Procedures to the development of disciplines relating to qualifications, technical standards and licensing pursuant to paragraph 4 of Article VI of the GATS.

According to a WTO Secretariat Note "measures falling within the scope of Article VI.4. are intended to serve regulatory or other public policy objectives. Their purpose is not to restrict trade, and if they have incidental restrictive effects on trade, Article VI requires that these effects should be the minimum compatible with achievement of the desired policy objective. Nor should Article VI.4 measures have discriminatory effects, as between foreign and domestic services and service suppliers. Measures are legitimate under Article VI so long as they meet the requirements of Paragraph 4. By contrast, measures intended to restrict trade and/or to discriminate between national and foreign suppliers are dealt with under Article XVI, Article XVII and the Annex on Article II Exemptions"³⁸.

A case has been made for complementing the national treatment obligation with a generalization of the so-called "necessity" test to counter the trade-inhibiting effect of

³⁶ WTO. Health and Social Services: Background Note by The Secretariat S/C/W/50 18 September 1998

³⁷ WTO. Op Cit.

³⁸ WTO .The Relevance of the Disciplines of the Agreements on Technical Barriers To Trade (TBT) and on Import Licensing Procedures to Article VI. 4 of The General Agreement on Trade in Services. Note by the Secretariat, WTO 11 September 1996 S/WPPS/W/9

such measures³⁹. The test is already applied to technical barriers to trade in goods, and is part of the recently established “pilot” disciplines for the accountancy sector. As an example in the case of health services, professionals like doctors would not be required to re-qualify, since the basic problem, inadequate information about whether they possess the required skills, could be remedied by a less burdensome test of competence.⁴⁰

Caribbean countries may wish therefore, to further examine the possibility of pursuing under Art. VI.4 the question of standards and portability of insurance as barriers to trade. Joint ventures with health-care funders to overcome the problem of non-portability of health insurance would also be important. In terms of cross border supply, the main thrust would be in Telemedicine where a new look at e-commerce and telecommunications would have to be taken. Some developing countries are already beginning to provide services in tele-diagnosis.

In conclusion trade negotiations in health services in the WTO have been stalled by a reluctance to accept that health care can be traded in the same way as goods and other services. Concern has already been expressed with the unintended implications of trade negotiations in other areas such as government procurement, TRIPS, competition policy, subsidies and investment on health care systems in terms of increasing costs and decreasing equity. Countries are therefore preparing themselves in a comprehensive way and attempting to see the type of domestic legislation that would be needed to preserve universal access to health care. Health tourism needs to be examined in such a broader context in order to draw more conclusive positions.

C.4.2: FTAA

One proposal in the FTAA is that the scope and coverage of the services chapter of the FTAA Agreement should be comprehensive and should cover, in principle, all service sectors and service suppliers. To implement this, a ‘top-down (‘negative list’) approach.’ is advocated. This means all services will be covered unless a particular FTAA country negotiates a reservation for a particular sector or measure, as Canada did in NAFTA for the health sector. As against the negative list approach is the positive approach which focuses on specific activities.

Health services have not yet come on the Agenda of the FTAA. The NAFTA experience would be instructive in that both MFN and NT are required to be given to cross border services and service providers coming from the other NAFTA countries. However, this duty is subject to a broad right to list service areas which are to be exempted from MFN and NT as a reservation.

The investment and services rules of NAFTA seek to contain the capacity of governments to regulate or otherwise intervene in health spheres of the economy. It is felt in some quarters that the influence of NAFTA’s investment and services rules will significantly exacerbate the problems already associated with privatization in that the rights accorded foreign investors and service providers under NAFTA limit government policy and regulatory options to a degree that is not true vis-à-vis domestic investors and

³⁹ Mattoo, Aaditya. Shaping Future Rules For Trade In Services: Lessons From The GATS. WTO. 8 August 2000

⁴⁰ Mattoo, Aaditya. Op Cit.

service providers under domestic law. These constraints undermine the capacity to preserve the essential features of a publicly funded health care system. The same is true with respect to the proprietary interests of foreign investors, which can be accorded much greater protection than is available to locals under domestic statutory or common law. These rights would make it virtually impossible for governments to retreat from privatization initiatives which gave rise to foreign investment

The FTAA would however, represent a huge market in health tourism and the possibilities for increasing the flow of health tourists through the portability of insurance could be enhanced. Already under NAFTA, efforts are underway between Mexico and the US to try and mutually extend insurance coverage to Mexican and US health providers. It may also be possible to achieve agreement on mutual recognition of standards to facilitate the movement of skilled personnel for the desired specialized areas in health tourism. As noted earlier, the Caribbean should examine a long-term strategy for dealing with health standards, accreditation and insurance portability that could begin in the WTO and be extended to the FTAA.

There are, however, some contradictions between free trade and comprehensiveness, universality, and accessibility to health care. Much will depend upon the integrity and broad application of safeguards. As in the GATS as well, a comprehensive approach that touches on investment, government procurement, subsidies, dispute settlement, TRIPS, etc will be needed to ensure a correct balance between equity and efficiency.

D. POLICY CONCLUSIONS AND RECOMMENDATIONS

D.1 Domestic Policies

D.1.1 Foreign Direct Investment

As regards foreign investment, the rapid growth in hotel investment in the Bahamas is related to the large investment in infrastructure. It is also connected to the fact that foreign investors are managing and running the businesses, marketing through the international networks and providing significant amount of training and employment to local residents. This would imply that adequate arrangements for the movement of natural persons are also critical.

Policy, regulatory, institutional and legislative barriers to foreign investment in health tourism have been highlighted in the region such as uncertainty and lack of transparency concerning work permits, Alien-Landholding Acts, and visas as well as the absence of information on government policies and regulations pertaining to the export of health care services. The lack of a set of formal regulations readily available to interested investors and governing standards for medical care, licensing, quality assurance and control procedures, clinical practice, and facilities operations has been particularly underscored. Policies regarding the licensing and approval of new technologies, treatments, and drugs were also underscored.

Taxes in relation to the purchase of property and the import of high technology medical equipment were also noted as another deterrent of foreign investment. Labor

laws are also seen as problematic for expatriates. It is difficult to obtain work permits and the uncertainty of renewal makes many foreigners reluctant to invest. In addition, the legal and regulatory constraints are subject to both interpretation and discretion. Approval times also involve a lot of uncertainty.

While countries are making efforts to eliminate these barriers, the question has been raised as to whether it is sufficient to eliminate barriers or is it also necessary to provide incentives? The debate on the granting of incentives to correct market failures has raged over the years without any firm conclusions and guidelines. The conditions under which incentives work or do not work are still not known with any precision.

An examination of incentive legislation in the six countries studied indicated that none of them offered special financial incentives for the health services industry but Governments in the region have the inherent right to take “off-the-book” decisions to offer special financial incentives. In an imperfect world, special incentives never go away, and, by far, the greatest competition for investment is among developing countries. The evidence from the Bahamas case study suggests that FDI can make a big difference and is responsive to liberal policies. Bahamas however, offered a range of incentives for hotel investment as laid out in the Hotel Encouragement Act and supporting regulations managed by the Office of the Prime Minister (OPM) through the Bahamas Investment Authority.

In the absence of an agreement among CARICOM countries as well as internationally acceptable conventions to limit unhealthy competition in the granting of incentives, special incentives will continue to stimulate investment in the region. The case of the Bahamas in hotel investment seems to illustrate that in spite of liberal policies to foreign investment that reduced barriers, special incentives were still necessary. The evidence in the health sector is not conclusive enough to suggest that countries could avoid using special sector-specific incentives.

In addition, in the health sector, financial investment incentives should be considered as only part of the total incentive package, in that liability and risk management issues could come up long after the investor has reaped the start-up benefits.

D.1.2. Policies to Ensure Universal Access

The question of meeting the social goals in the health sector in the context of freer trade and in a search to increase exports of health services comes down to whether complementary policies can be devised and implemented which ensure that access for the poor is not jeopardized. For instance, countries have experimented with dual health care systems (public and private) and with vouchers - which could, for instance, be financed by a tax on earnings from "exports" of health services. Equally, exports from a greater inflow of health tourists through the entry of FDI and foreign specialists could generate more opportunities locally which in turn could reduce emigration of skilled personnel - especially if the skills of foreign and domestic personnel are complementary which immigration policy can ensure.

There may also be opportunities to provide greater balance through the contracting of private services on behalf of the population. Work on national health insurance would also be a key instrument in ensuring equity and re-balancing distribution

of financial resources for health and the impact of health tourism would need to be included in the modeling.

D.1.3. Regulatory Policy on Standards and Accreditation

In some cases the Ministry of Health has to be given a more strategic role in ensuring the improvement of the health of the population through public health interventions and setting of national policies and standards. Regional agencies that act as regulators by creating standards for industry regionally and internationally should be encouraged. The Nursing Body promotes a common curriculum and regional standards. The Regional Nursing Examination tries to stem the rising trend of temporary emigration of nurses from the Region. The Caribbean Association of Medical Councils (CAMC) is attempting to promote freer movement of physicians throughout the Region by developing a regional examination, promoting registration, licensing, and standards. CAREC, in collaboration with CAST (Caribbean Action for Sustainable Tourism), is implementing a project on Healthy Tourism with the overall goal to improve the quality and competitiveness of the tourism industry. The project purpose or end of project impact will be the establishment and dissemination of quality standards, systems, and registrations designed to ensure healthy, safe and environmentally conscious products.

Regional harmonization could therefore provide a basis for improving local standards and gaining international recognition. Foreign investment can also help overcome one of the biggest obstacles which is the lack of familiarity with the health providers in the region by health tourists and a concern with standards.

Standards of operation for alternative systems of medicine in the country are needed in many countries. The emphasis so far has been on public health standards of the hotel industry so to safeguard the visitors' health. Programmes for developing a framework for monitoring activity or standards or care for this industry are needed.

International accreditation will be key to obtaining medical insurance and medical liability coverage. Even if insurance companies developed products that would allow international coverage in the Caribbean (as Caribbean insurers do now for locals seeking care overseas), the price of that coverage rises with more freedom of choice both in terms of provider and range of services covered. International accreditation will facilitate Caribbean-based facilities to be part of globally recognized networks of a certain quality and to be properly rated for risks. The opportunity will also be provided to broaden the range of services to more aesthetic ones normally outside of any covered insurance package e.g. cosmetic surgery.

The difficulties in obtaining international accreditation are related to the absence of well-established standards, the ad hoc nature of the accreditation procedure, and the high cost of the required improvement in standards. The anticipated increase in tourist flows would justify the required investment in some cases. International accreditation may also not be sufficient to ensure that patients will obtain insurance coverage.

D.2 Key International Policy Issues

A major trade objective to increase the flow of health tourists to the region by extending insurance coverage and by improving standards. International portability of

insurance, recognition of professional and hospital standards should be considered priority areas for discussion and future work. It would be worth considering how the GATS negotiations could be used to make some gains in these areas as a stepping stone for going further in the FTAA. Caribbean countries may wish therefore, to further examine the possibility of pursuing under Art. VI. 4 the question of standards and portability of insurance as barriers to trade.

D.3: Strategic Planning for the Sub-Sector

In summary, the priority actions or components for the development of a health tourism strategy and plan should include:

- Establishment of a joint Trade/Tourism/Health mechanism to lead the development and implementation of the strategy covering both public and private sector activity including a communication programme to engage the wider public in the development;
- Active support of the Health Sector Development/Reform Programmes with particular attention to strengthening the regulatory framework, health care financing reform, planning for new hospital infrastructure and monitoring of private sector activity.
- Active support to the Sustainable Tourism Strategy initiatives and to review tourism master plans for their implications for use of local health services by tourists and for regulation of the health tourism 'products' being provided in tourism infrastructure.
- Establishment of an incentive programme for FDI in health sector targeted at health tourism and designed to attract capital flows as well as the supporting links to the export health market, management and training resources.
- Continued review of trade negotiating requirements both regionally and internationally so as to ensure that CARICOM proactively adjusts to the changing global environment as it relates to health services and that the health and tourism sectors are aware of the potential impact of these negotiations.
- Countries will need to decide if and how they would like to move forward with this agenda. A project could be designed on a regional basis or a country basis in terms of piloting and sharing lessons. However, it is important that this should be carefully aligned to other regional and national activities or projects so as to avoid duplication of effort and resources.
- The development of complementary policies which ensure that access for the poor is not jeopardized. For instance, countries have experimented with dual health care systems (public and private) and with vouchers - which could, for instance, be financed by a tax on earnings from "exports" of health services. There may also be opportunities to provide greater balance through the contracting of private services on behalf of the population. Work on national health insurance would also be a key instrument in ensuring equity and re-balancing distribution of financial resources for health and the impact of health tourism would need to be included in the modeling;

- It is important in designing national strategies that they should be carefully aligned to other regional and national activities or projects so as to avoid duplication of effort and resources.

D.4: Trade Negotiations

D.4.1. WTO

- National development policy should first determine the costs and benefits of promoting health tourism exports and protecting equity in the sector. A correct balance should be struck;
- Specifically for WTO scheduling purposes in the area of Health Tourism, CARICOM member states would want to try to more adequately cover the existing and potential activities in health tourism. As indicated above, at present rehabilitation, wellness programs, spas, cosmetic surgery are some activities that are not properly classified and covered by the categories in the Sectoral Classification List . Further clarification from the WTO Classification Committee is needed as to how some of these services fit into the classification. A more detailed and in-depth classification exercise of health tourism activities is needed as a precondition for further negotiation and one that would make the link between health and tourism activities more specific;
- The activities that CARICOM countries would wish to open up in Health Tourism are mainly those requiring significant inflows in foreign investment as well as movement of skilled natural persons, the two most important modes. These would be in the capital- intensive and skill-intensive areas where trade barriers should be reduced or eliminated;
- Direct Foreign investment can act as a spur to a greater influx of health tourists which would be an attractive clientele. Foreign investment can help overcome one of the biggest obstacles which is the lack of familiarity with the health providers in the region by health tourists and concern with the standards;
- Domestic Regulation will be critical in terms of channeling foreign investment in the specialized areas in which they are needed and avoiding any inequities that could result;
- For purposes of transparency, it would be useful as well for CARICOM countries to state clearly in the scheduled commitments the conditions under which foreign investment is permitted;

- Other CARICOM countries besides Jamaica, St Lucia and Guyana, need to revisit their commitments or non-commitments in this sector. Trinidad and Tobago appears extremely restrictive by making no commitments in this area. In certain specialized health tourism areas especially in the treatment and rehabilitation sectors discussed in TABLE 2, CARICOM countries, especially those with a vocation in tourism may wish to introduce greater liberalization;
- The development of Health tourism would require some further relaxation of work permits to facilitate attracting the skills particularly in the specialized areas of Health tourism as discussed above. Most people think that regulations are sufficiently flexible and operate well on the basis of demand. Applicants for work permits, however always tend to refer to the uncertainty surrounding the process, the cost as well as the long waiting periods in some cases. Trinidad and Tobago has been signaling a change in policy in the Health sector by confining the movement of natural persons to just licensing and qualification test in some well defined areas. The rest of the region may wish to re-examine the current approach to see to what extent greater up-front transparency and commitment could facilitate the acquisition of the needed skilled personnel;
- Modes 1 and 2 are not as binding as Modes 3 and 4. Already significant commitments have been made in these modes. A major trade objective under Mode 2 is to increase the flow of Health Tourists to the region including those covered by insurance. A critical factor therefore remains the portability of insurance. Negotiations on Health Insurance in the WTO would be important. Joint ventures with health-care funders to overcome the problem of non-portability of health insurance would also be important.
- In terms of cross border supply, the main thrust would be in Telemedicine where a new look at e-commerce and telecommunications would have to be taken.
- Concern has already been expressed with the unintended implications of trade negotiations in other areas such as government procurement, TRIPS, competition policy, subsidies and investment on health care systems in terms of increasing costs and decreasing equity. Countries are therefore preparing themselves in a comprehensive way and attempting to see the type of domestic legislation that would be needed to preserve universal access to health care. Health tourism needs to be examined in such a broader context in order to draw more conclusive positions.

D.4.2: FTAA

- A positive approach which focuses on specific activities may be better able to safeguard the interests of the health sector in the region.
- Chances for increasing the flow of health tourism through the portability of insurance could be enhanced in the FTAA. CARICOM countries may wish to elaborate some proposals in the area of Health Tourism Insurance.
- CARICOM should pursue mutual recognition of standards to facilitate the movement of skilled personnel for the desired specialized areas in health tourism.
- Special attention should be paid to the integrity and broad application of safeguards as well as special treatment for smaller economies;
- A comprehensive FTAA approach that touches on investment, government procurement, subsidies, dispute settlement, TRIPS, etc will be needed to ensure a correct balance between equity and efficiency.

APPENDIX 1: SELECTED COUNTRY EXPERIENCES

2.3.1 ANTIGUA AND BARBUDA⁴¹

The Crossroads Centre at Willoughby Bay, Antigua is a non-profit, 36-bed residential facility located on 20 acres in the southeast coast of Antigua, with an excellent view of the sea. The 29-day program, based on the Twelve Steps of Alcoholics Anonymous (AA) helps clients recover from alcohol and other dependencies. Crossroads is currently rated third in the world.

The Centre was established in October 1998 at a cost of \$7 million. The Centre, initially financed by rock star Eric Clapton who resides on Antigua, was seen as a way to “give something back” after the success of his own rehabilitation. Mr. Clapton also participates in fund-raising: he sold 120 of his personal guitars to raise \$5 million for a scholarship program for the Centre.

The month-long stay costs \$9,500 inclusive of accommodation and treatment (of which \$500 is a reimbursable medical deposit). The cost is much less than other residential facilities: \$23,000 for Betty Ford, and \$14,000 for Hazelden centers.

Contrary to its initial mission of serving the Antiguan population, the clientele is mainly international, from Europe, North America and South America. However, a scholarship program makes treatment available to Antiguan nationals, who receive subsidies up to 100% of the cost. Other West Indian clients are heavily subsidized as well.

In Phase 1, each client is given a complete medical evaluation by the doctors and nurses, and is assigned an addictions counselor. The team designs each client’s individual treatment needs. In Phase 2, the client receives individual and group therapy; exercise therapy; massage therapy; classes in yoga, stress management and nutrition; lecture or scheduled discussion groups and beach meetings on alcohol and drug dependencies, emphasizing on-going recovery. Upon completion, each client is referred to continuing care for further treatment and support.

⁴¹ The basic information presented herein was provided by **Ms. Judith A. Joseph-Martin**, Outreach Representative of Crossroads Centre (tel. 268-562-0035; fax. 268-562-0036).

There are more than 20 full-time staff at the Centre, as well as other contracted staff (massage therapist, exercise therapist, etc.). Four of the clinical staff are not native to Antigua. The Centre is expanding by developing a half-way house in St. John's for patients who have relapsed. A Family Retreat Centre is being developed as well.

The Centre has an occupancy rate of approximately 40% which varies by season, with highest demand in the winter months (Brenzel and Le Franc, 2000). In 1999, the Center was able to cover its operating costs from operating revenue, which is unusual for a start-up industry. The Centre is marketed through offices located in California and London using 800 numbers. In addition, Crossroads maintains a website (www.crossroadsantigua.org).

Other rehabilitation services of this type are available in Antigua and the Caribbean. For instance, the Centre refers patients who require a longer program to Mt. St. Benedict in Trinidad. The Turning Point (St. Lucia) and Charter House (Grenada and St. Martin) are both government run facilities in the Region. In addition, the Mount St. John's Medical Centre in Antigua is under development and will be a 187-bed state of the art hospital catering to local and foreign clientele. It is expected that this hospital will provide medical and support back-up to the Centre.

The Centre contributes to the local economy through employment of Antiguan nationals as support personnel, administrative and clerical staff, and clinic professionals. Approximately 90% of the materials and supplies used in the Centre are sourced in Antigua, which also contributes to the economy. Because the families of clients utilize tourist facilities, and the Centre hosts alumni reunions of clients and spouses, other sectors in the economy benefit from the operation of this facility. Nevertheless, because some of the inputs and staff come from outside the country, it is difficult to gauge the net foreign exchange contribution.

One of the major drawbacks is that clients cannot claim insurance for the services provided at Crossroads. Recommendations include opening up of international accreditation, and creation of regional bodies to handle accreditation. Because of the specialized nature of rehabilitative services, and the strong competition which exists for clientele, this type of activity may not have the strongest growth potential for the Caribbean. Other issues, such as the perception of the local population towards the

clientele, may also prevent widespread growth of this type of health service in the Region.

This case suggests that while the goal was to provide dependency services to the local population, it was necessary to cultivate an international export market first to generate sufficient resources to subsidize patients from the West Indies. This type of model is potentially replicable in the future.

Bahamas

The Commonwealth of Bahamas with an estimated population of 300,000 has the highest GDP/capita in CARICOM of US\$11,940 with a estimated 4.3% of GDP spend on health of which 42% is private expenditure (PAHO 1999). Most of the overseas care is provided in Florida. Tourism is the largest economic sector, followed by the financial services, with an estimated 4.2 million visitors in 2000, 2.0 million stay over and 2.2 million cruise ship visitors. About 85% of tourists originate in the USA, 7-8% from Europe, 5-6% from Canada and 1% from other countries.

Health Tourism

Like other islands with a thriving tourism industry and a culture and economy that is geared to looking at tourist markets, there are a range of health tourism activities in the Bahamas. Four of the major hotels have spa services and one hotel, the Yoga Retreat on Paradise Island offers a resort package based on complementary healing and a high return visitor rate. Other health services have developed for use of tourists while on the islands including dialysis services, and herbal treatments. The private hospital group, Doctor's Hospital, reports that about 15% of its caseload is geared towards tourists seeking care during their visit. The public sector facilities do not feel that tourists use their facilities to any great extent, as most of their specialists also have private offices outside of either Princess Margaret Hospital or Doctor's hospital.

A small 12-bed hospital in Lyford Cay has a cosmetic surgery service geared to tourists, and is considered quite exclusive by virtue of price and reputation. No active marketing is done of the service, which indicates that clients are offered this option by the surgeons involved with Lyford Cay as part of their practice in the USA. There is resident staff in the hospital, and locals are known to go there for routine care.

The turnaround in tourism in Bahamas in the last few years has resulted from a surge of FDI in Paradise Island in the Atlantis Resort, and the acquisition of two major hotels from the Government, the British Colonial by the Hilton group and the Sandals resort.

Bahamas offers a range of incentives for hotel investment as laid out in the Hotel Encouragement Act and supporting regulations managed by the OPM through the Bahamas Investment Authority. It is acknowledged that this growth has come about not only because of investments in infrastructure but also because the foreign investors are managing and running the businesses, marketing through the international networks and providing significant amount of training and employment to local residents.

No financial incentives are available for the health sector although offshore medical centres are listed in the group of investment opportunities in the Bahamas Investment Guide. Even if the BIA were to have financial incentives to offer prospective investors, the project would still need to be approved technically by the MoH and licensed by the regulatory councils. The latter determines local accreditation based on availability of local professionals in the same field. Further, a condition of business licensing is that the foreign investor can only provide services to non residents – if it found to be serving locals, the license can be revoked.

Distinct from any other private provider in the Caribbean, Doctor's Hospital is actively engaged in providing care to tourists, has embarked on the development of a health insurance product, and is presently commissioning an ambulatory centre and wellness product in affiliation with an internationally recognized fitness agency to specifically target vacationers looking for a fitness oriented holiday, complete with medical assessment and support, and looking at linking their three facilities through telemedicine. The extension of the network to the family islands is being considered and will have a link to the USA. Doctor's Hospital also has recognized the need to be internationally accredited to be able to offer its services to the insured American market, and in its 2nd of an estimated 3 year process to become accredited by the Joint Commission for International Health Resources which is a affiliate of the Joint Commission for the Accreditation of Health Facilities in the USA.

The Bahamas also has enacted the International Persons Landholding Act that allows foreigners to own homes in the Bahamas. The condition has been that the value of the home exceeds a certain value and their entry is facilitated with the Home Owner's Residence Card which is renewed on an annual basis by the Department of Immigration. This facility can be used to enable the development of retirement communities in the

Bahamas, as the proximity to the USA and lack of security problems would be major incentives for this development. However, a known constraint is the quality of health care services, particularly on the smaller islands.

Further, the type of second home-owners have predominantly been professional and upper income earners who are not necessarily of retirement age. The development primarily in New Providence and to a lesser extent the smaller islands has been low density housing with the owners contributing to the development of the communities rather than they requiring any real support from the community. Retirement communities would be high density development and possibly middle- to upper-middle income elderly who would place greater demands on the local health system and have higher environmental impact.

The public sector is recently embarked on a reform programme, in which the efficiency of the hospitals is expected to improve through the establishment of the Public Hospitals Authority which will manage the operations of these facilities. Infrastructure improvement programmes are expected for the main referral hospital, Princess Margaret Hospital in Nassau, and 'mini hospitals' are being planned for the family islands. Tourism promoters and the BIA should be involved in these developments to determine if there are additional requirements for the tourism industry, and if there are private sector partners who may be willing to either finance or compliment these developments with their projects.

Trade Issues

The Ministry of Foreign Affairs was clear that the potential for health tourism was of interest to the Bahamas, but that there were several trade issues and implications that would need to be carefully managed in moving forward in this area. These included:

- *Movement of consumers:* The management of health risks to the Bahamas in terms of communicable diseases is a concern, but also if there was a risk of decreased access to health care as a result either through an increase in price or loss of local labour. Systems are being put in place to open market for retirement communities
- *Movement of natural persons:* Care is being taken not to distort the local labour market so there is a need to look at the movement of labour into the country to support these offshore medical centres.

- *Foreign Direct investment:*
 - Capacity to manage quality of care for research and experimental care programmes has to be improved. Bahamas is a less regulated environment than the US and Europe, and therefore, needs to be affiliated with a reputable programme or facility;
 - The services must benefit the local population by stimulating the quality of the local health services. It may not be able to ring fence this service as has been done for other services, such as gambling.

Barbados

Barbados, with a population of approximately 265,000 is a moderately developed Caribbean country with a GDP per capita of \$7,379 (CTO, 2000). The country has enjoyed sustained positive economic growth over the past decade, and enjoys a stable political system.

A. Potential for Trade in Health Services in Barbados

Barbados has many characteristics important for health tourism; namely, excellent climate and environment; well-trained health practitioners; reliable telecommunications and good transport infrastructure; excellent hotel and tourism services; an educated population; and, lower labor costs than most developed countries (Brenzel and Le Franc, 2000; Shepard and Vargas, 1994).

The Ministry of Health has entertained the idea of promoting health tourism in the past. In 1994, the government and the World Bank commissioned a study to evaluate the potential of health tourism in the country, particularly focusing on the possibility of using the renovated, 72-bed St. Joseph Hospital as a health tourism facility. This study suggested promising areas for tourist health services including 1) expansion of emergency care for tourists; 2) health spas, including alternative medicine, fitness, and chronic disease management; 3) and, selected services, such as rehabilitation services, drug and alcohol dependency centers, or cosmetic surgery (Shepard and Vargas, 1994).

A workshop organized by the World Bank highlighted some of the potential obstacles to trade in this area, such as travel costs; higher wages and hotel rates compared to other Caribbean countries; lack of portability of health insurance; time and cost required to develop health tourism; and, a general reluctance of patients to seek medical care in an unknown environment (Hope-Price, 1994). Unfortunately, this initiative has not been pursued since the early 1990s, and there is presently no government strategy to include trade in health services as part of economic development.

The present potential for trade in health services was assessed for Barbados based on a series of interviews with public sector officials, private providers, Caribbean agencies,

and a review of documents and publications. Persons contacted and references are provided in Annexes 1 and 2. The discussion is based on the four modalities of trade; namely, consumption abroad, movement of natural persons, foreign direct investment, and cross-border trade.

1. Consumption Abroad

1.1 Curative care

Curative health tourism focuses on providing treatment, diagnostic care, or surgical care to patients who travel from their own country. Barbados is able to provide health care services to visitors through its well-developed health sector, comprised of a system of polyclinics, district hospitals, and the Queen Elizabeth Hospital in the public sector, which serves as a referral hospital for the Eastern Caribbean. Approximately 150 private physicians also practice in the country (BAMP, 2000). The private sector also includes private emergency clinics and ambulance services, laboratories and diagnostic services, and a private hospital (Bayview Hospital).

Barbados has a history of providing health care to foreign visitors. For instance, in 1990, health care for visitors represented 2.1% of all admissions and 1.6% of all accident and emergency visits to the Queen Elizabeth Hospital (Walters, et al, 1993). Most of these visitors originated from the UK, and fell ill while on holiday. The average hospital stay for visitors was 11.7 days compared to 7.0 days for Barbadians, at a cost of approximately \$Bds 1.1 million per year (\$550,000), or 2% of all hospital costs.

Bayview Hospital regularly supplies health services for cruise line passengers through contract arrangements with cruise line operators, such as Goddard Shipping and DaCosta Shipping. In fact, cruise line operators are so confident in the medical services provided in Barbados, that they often hold passengers on ship until they arrive in Barbados for medical attention.

1.2 Preventive and promotive care

Preventive health tourism includes activities aimed at holistic healing or maintenance of the balance within the body (MOT, 1998). The Ministry of Tourism has been interested in promoting preventive health tourism to foreign visitors to Barbados. In 1998, a pilot study was conducted to ascertain the importance of health as a reason for travel to Barbados. This study found that visitors attached a high degree of importance to their health, but very few visitors understood the concept of health tourism. The majority of persons interviewed would be willing to pay for organic foods and stress-reduction services. A more comprehensive market survey was recommended (MOT, 1998). Presently, a number of hotels provide fitness and day spa services, such as facials and massage therapy. However, very few hotels have been designed which incorporate alternative healing in a spa facility. One exception is Sandy Lane Hotel which is being renovated to include a three-story, 45,000 square foot spa facility with 11 VIP suites. Services to be provided include: hydrotherapy, massage, aromatherapy, ayurvedic treatments, thalassotherapy, among others. Spa services will be a la carte in terms of pricing. The spa facility is being developed with a consulting firm, Espa International. Therapists will be mainly from Barbados who have undergone an eight-week training session, with continuing training throughout their employment. Physician and physiotherapy services will be available on-call.

Sandy Lane is marketed as a hotel with a spa. They expect their guests to come primarily from the U.K., Europe and the U.S. In fact, they hope the spa will help develop the American market for the hotel. Managers feel there is little competition for their spa services within the Caribbean. The spa is modeled on other international resorts and spas, such as the Oriental Hotel in Bangkok, and is expected to attract this type of clientele.

Because this type of facility is new to Barbados, Sandy Lane has found the government very keen to assist in its development. One drawback has been the superficiality of some of the training courses in massage and aesthetics offered on the island. There is need for upgrading of these courses (to provide basic training in physiology and anatomy, for example), as well as to provide certification. Management believes that licensing and regulation of these types of practitioners will only strengthen this type of tourism product in Barbados.

There are several smaller establishments providing alternative and complementary medicine and healing in Barbados, and a few of them advertise directly to tourists. Examples include the Caribbean Stress Management Institute, St. John; Windward Natural Health, St. James; The Integrated Natural Health Shoppe and Clinic, Hastings; and Reiki School of Natural Healing. In addition, there is a wide range of alternative and complementary practitioners on the island who offer Reiki (e.g., The Barbados Reiki Association; Reiki School of Natural Healing), acupuncture, homeopathy, massage therapy, aromatherapy, and iridology, among others.

Based in Barbados, the Caribbean Association of Complementary and Alternative Medicine (CACAM) is a professional Caribbean association of alternative and complementary practitioners, groups and organizations. The purpose of CACAM is to ensure the integration, acceptance and expansion of alternative and complementary medicine within the health care system through professional and public education; development of practice standards, and advocacy and research.

CACAM supports alternative and complementary medicine practice in the areas of acupuncture/ acupressure, aromatherapy, Chinese medicine, chiropractic medicine, homeopathy, massage therapy, nutrition, polarity therapy, Reiki, and yoga, among others.

The organization was started at the end of 1998, and has approximately 35 members.

CACAM hosts a popular annual symposium on alternative and complementary medicine in Barbados.

Alternative and complementary practitioners have trained themselves at their own expense, and represent a tremendous, yet untapped, human resource in the Region. CACAM and its members represent a possible resource for resort operators to tap into in establishing holistic health and spa treatments (Brenzel and Le Franc, 2000).

The Ministry of Health is aware of the proliferation of paramedical practitioners in Barbados, as well as the growing use of alternative medicine by the Barbadian population and visitors. There is a well-received, call-in radio show hosted by one of the island's alternative practitioners. The Ministry of Health has established the Paramedical Professions Council to establish standards of operation for alternative systems of medicine in the country, and to provide for registration of professions supplementary to the Conventional Medicine (Paramedical Profession Act- Cap 372c). However, there is

currently no licensing or registration in operation. Practitioners are interested in legislation which would integrate them more into the mainstream of health care in Barbados (Homer, D., 2000).

1.3 Convalescent and elder care

Because of the aging population worldwide, the need for health care services for the elderly is rising. The number of senior arrivals (persons older than 50 years) to Barbados increased from 103,327 to 133,202 between 1989 and 1998, representing an increase of 29%. Figure 1 shows that the share of senior arrivals has risen to 29% of total arrivals to the country, and the share of arrivals of persons older than 65 years old is approximately 7% (CTO, 2000). Therefore, the growing number of traveling seniors presents a special opportunity to Barbados in terms of marketing and providing health and wellness services.

There are a few private nursing homes operating in Barbados which have, on occasion, offered services to visitors. One of these is the Barbados Home Nursing Agency, which began operation in 1982. This facility provides convalescent care for patients coming out of the Queen Elizabeth Hospital. The facility is staffed by trained nurses with physicians on call. The occupancy rate is approximately 70% in this 18 bed facility, though occupancy is seasonal. The daily rate charge is less than \$Bds 500, though this varies depending upon the intensity of care. On average, patients stay three months in the facility, with six months being the maximum length of stay. Financially, the facility is surviving, though there are very tight margins with this type of service, as the cost of labor and benefits are high.

Management feels that government could provide additional financial support and incentives, such as waiving or reducing the employer contribution to the National Insurance Scheme. It appears that there is room in Barbados for additional facilities, as competition in this domain is not that great.

1.4 Other types of services

There is one primary cosmetic surgeon on the island who performs breast reduction, liposuction, and abdominal plasty. Patients come from the U.S., the UK, and other

Caribbean countries. Given how tightly regulated the physician market is in Barbados, it is unlikely that this is an area which will be easily expanded in the future.

2. Movement of Natural Persons

Like most Caribbean countries, Barbados both imports and exports health professionals. Data on the migration of health professionals both into and out of Barbados were difficult to come by for this study. The Barbados Association of Medical Practitioners (BAMP), an association that represents primarily physicians practicing in the private sector, lists over 100 physicians as members.

The Medical Council determines who is accepted to practice in Barbados. This body meets on an *ad hoc* basis depending on the number of applications pending for review. They receive approximately 20 applications per month. Foreign applicants generally come from the U.K., U.S., and Africa (particularly Nigeria). Applications must contain proof of medical qualification (such as a diploma); a certificate of good standing from the previous place of employment; identification documents, such as a passport or other ID; details of medical internships, supplemented by a curriculum vitae; letters of recommendation; and, a completed application form.

Each application is reviewed by the Assessment Committee of the Medical Council. Applicants are either granted a full approval (without conditions); a temporary approval (for 2-3 months); or, a specialty approval. Successful applicants must have graduated from an accepted university or college, which is determined by the WHO World Directory of Medical Schools. Approved applicants must obtain a Work Permit, which is usually sought by the MOH on their behalf.⁴² Each practitioner in Barbados must register and pay an annual fee of \$750. While most foreign physicians come to practice in the public sector, there are no restrictions on establishing a private practice other than submitting a letter to the Council.

3. Foreign Direct Investment

⁴² Most overseas doctors are recruited to fill vacancies in public health facilities, so that the MOH would be responsible for submitting the paperwork related to obtaining a Work Permit.

The Barbados Investment and Development Corporation (BIDC) strives to provide a favorable investment environment within the country, in support of the International Business Companies Act, 1991-24. Major incentives are provided for the offshore business sector, such as:

- Low taxation rates
- Exemptions from exchange controls and duties
- Tax holidays
- Double taxation treaties
- No capital gains taxes
- No restrictions on repatriation of net income earned by individuals or companies during tenure in Barbados
- Privacy of financial information

The MOH is not formally involved in the application and approval process of foreign direct investment for health services in the country. Investors interested to develop a health facility or practice can do so without MOH approval, by working through the Chamber of Commerce, the Barbados IDC, and the Office of Economic Affairs.

Island Dialysis is one of the few examples of direct foreign investment in health in Barbados. This facility is operated by the Atlantic Healthcare Group, Inc. out of Ontario, Canada, which also runs similar facilities in Jamaica, St. Lucia, and Puerto Rico. The facility began operation in Barbados two years ago, and employs local staff of four nurses, with two physicians who act as consultants to the facility. While they cater primarily to tourists, they have six local clients. They average approximately 30 clients per month and have 10 dialysis machines. The company advertises its services in several trade magazines, and has a website with links to tourist facilities, information about each Caribbean island, and support services.⁴³ Patients are charged \$320 per treatment for a less than three-week period; \$290 for more than a three week period; and \$280 for more than five weeks. A deposit of \$640 is required to secure a dialysis spot.

⁴³ The website address is: www.islanddialysis.com

4. Cross-border Trade

The area of cross-border trade focuses on information and services that can be passed across borders without movement of patients or providers. Examples of this mode of trade include telemedicine, shipment of laboratory samples, and information processing. Barbados currently participates in the shipment of laboratory samples that cannot be evaluated on the island to Miami. Patients are generally charged for shipment costs, of up to \$74 per sample. Approximately 30 samples per month are sent overseas for evaluation.

Telemedicine is a computer-based technology, which can assist in providing services which are not locally available, or to treat patients in rural areas through more cost-effective home-base care. Telemedicine is currently not available in Barbados. The MOH believes this is not a viable option for health tourism as many practitioners and MOH personnel do not have access to computers, nor are they particularly computer literate.

There is a tradition of sharing services between Barbados and the other islands of the Caribbean, particularly the Eastern Caribbean. For instance, QEH has served as a referral hospital for the Eastern Caribbean, as well as a center for renal dialysis. However, the hospital was having difficulty receiving reimbursement for services provided to non-Barbadians, so that this service is no longer available to the same magnitude.

B. Constraints and Barriers to Trade in Health Services in Barbados

Several barriers to trade in health services have become apparent as a result of this investigation. Most of these barriers are internal to the market in Barbados, though there are some which apply to the external market as well.

Internal barriers

There is a feeling that provision of medical services for wealthy tourists may “crowd out” provision of quality health care for Barbadians. This is particularly true when considering the limited number of nurses and various competing interests in this area. The additional

costs of establishing services aimed at the tourist market may prohibit development in this area, unless special incentives are given by the government. Finally, there are concerns whether the MOH has the current capacity to coordinate aspects of health tourism, such as licensing, regulation, accreditation, monitoring, and financing. Some of the barriers to free trade in the area of preventive and promotive health services include: 1) variation in training, expertise, and experience of alternative and complementary practitioners; 2) liability issues related to lack of practice standards and non-registration of practitioners; 3) adequate market research as to real demand for these types of services; and, 4) availability of medical back-up, particularly for smaller establishments.

External barriers

First, there is general skepticism among the professionals interviewed as to whether persons will feel confident enough to travel to a foreign place to receive general secondary or tertiary medical services. Second, persons coming for medical care will need to pay out-of-pocket, so that the market for consumption of health services will be primarily from those population groups able to pay. This limits the potential of health tourism when patients cannot use health insurance to finance their care overseas.

Persons Contacted

Barbados

Basil Levine, Barbados Investment & Development Cooperation, St. Michael

Basil Springer, Caribbean Development Bank, The Pine

Dr. Beverly Miller, Chief Medical Officer, Ministry of Health, Jemmotts Lane, Bridgetown, St. Michael

Bridgette Laurayne, Director of Leisure, Sandy Lane Hotel, St. James

Dr. Carol Boyd-Scobie, Pan American Health Organization/CPC, St. Michael

Ms. Boyce, Secretary to the Medical Council, Ministry of Health, Jemmots Lane, St. Michael

Cecil Miller, Senior Project Officer, Caribbean Development Bank, The Pine

Dorothy Davidson, Nursing Director, Barbados Home Nursing Agency, Christ Church

Gabrielle Springer, Ministry of Tourism, St. Michael

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John Morris, DaCosta Mannings Shipping

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North America

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Dr. Cesar Viera, Coordinator, Public Policy and Health Program, Health and Human Development Division, Pan American Health Organization

Dr. Karen Sealey, Chief of Analysis and Strategic Planning, Pan American Health Organization, Washington, D.C.

Maggie Huff-Rouselle, Director, Strategies for Sustainable Development, Montreal, Quebec

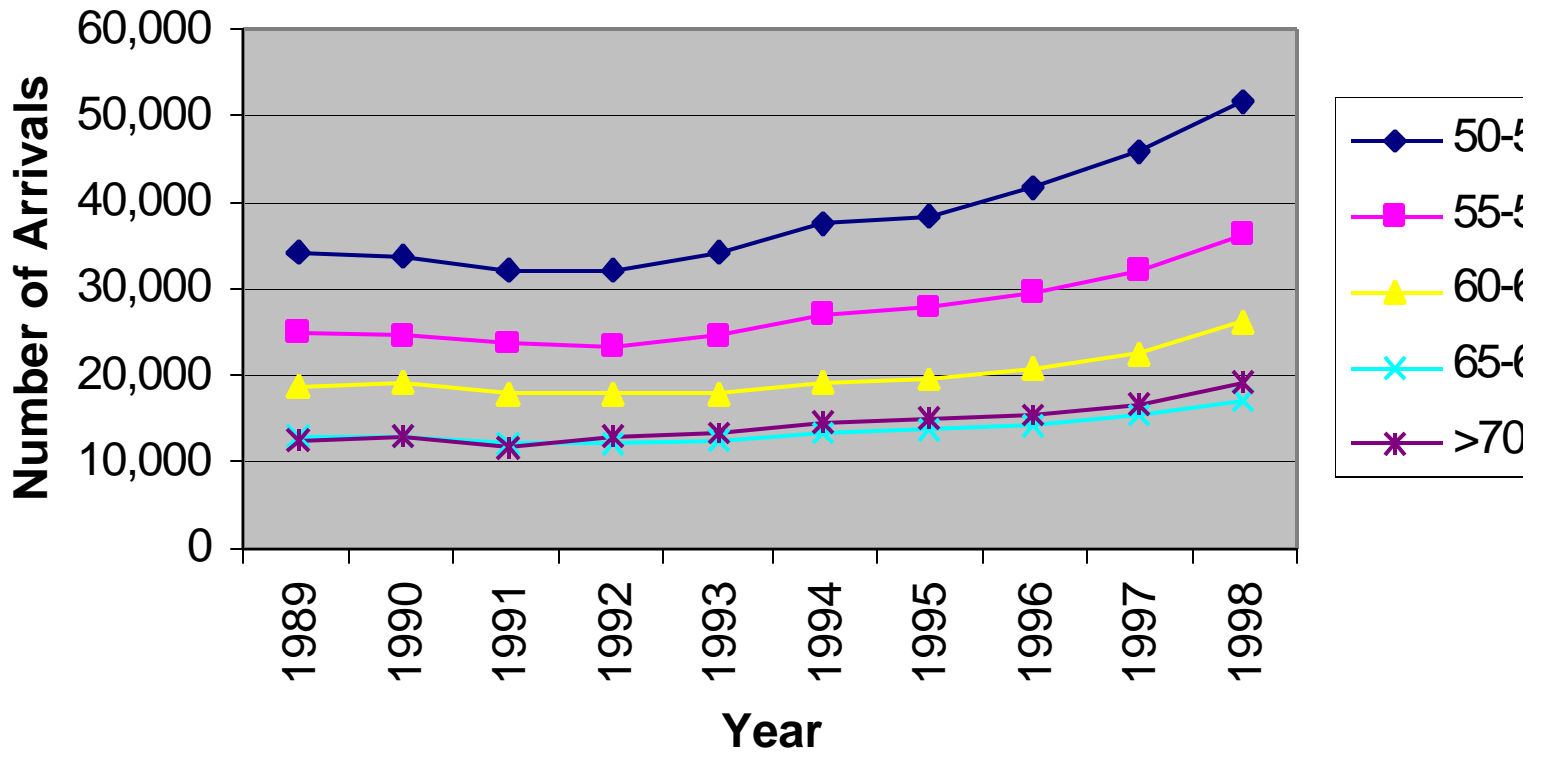
Dr. Monica Bolis, Regional Advisor in Health Legislation, Pan American Health Organization

Patricio Marquez, World Bank, Washington, D.C.

Ruth Levine, World Bank, Washington, D.C.

Tom Mullarky, National Institutes of Health, Center for Complementary and Alternative Medicine, Bethesda, Maryland.

Trend in Senior Arrivals to Barbados



CUBA

One of the government's objectives is to convert Cuba into a world medical power (UNCTAD Secretariat, 1998). Cuba has undertaken a multifaceted export strategy which includes sending medical personnel abroad, attracting foreign patients to specialized clinics, and establishing training schools for foreign medical students.

The Cuban government views health care and tourism as having the greatest growth potential of their export sectors (Huff-Rouselle, et al, 1995). Cuba began providing health services to tourists in 1989, as part of an overall economic development strategy. This strategy has three aspects. The first area for health tourism is based on the Cuba's health spas and mineral springs. The second area is traveler's medicine—providing emergency care and medical back-up for tourists. Thirdly, Cuba encourages people from other Caribbean islands and Latin America to come to the country for specialized medical care. Table 3 shows the range of health services provided to visitors.

Table 11: Health Tourism Services Provided by SERVIMED

Type	Centers Providing Service	Diseases Treated	Setting	Cost
Medical Services	Placental Histotherapy Center	Vitiligo, Psoriasis, Alopecia	Outpatient	\$250
	Pigmentary Retinosis Center	Night Blindness	21 Inpatient days	\$7,000 plus surgery
	Aged/Rehabilitation Center & Alternative Medicine	Geriatric Evaluation	Outpatient and Inpatient	\$200 - \$500

	General Surgical Services	Organ Transplantation (heart-lung, liver, pancreas)	Inpatient	\$18,000 - \$80,000
	Retinosis/Pigmentary Microsurgery Center	Myopia, Astigmatism, Glaucoma, Cataracts	21 Inpatient days	\$7,000
	Neuro-surgical Regeneration	Parkinson's, Spinal Chord, Encephalic trauma, Huntington's chorea, Alzheimer's	7 – 38 days	\$2,800 - \$8,000
	Underwater Medicine	Check-up for divers	Outpatient	N/a
	Drug Addiction and Rehabilitation	Detoxification and drug rehabilitation	100 days	\$2,000 - \$13,500
Medicinal Spas	Medicinal spa	Restoration of health	Outpatient	
	Biotop	Physiotherapy, Massage, Acupuncture, Digitopuncture, Exercise	7 days, outpatient	\$400 - \$600
	Anti-stress	Jacuzzi, sauna, massage, diet	7 days, outpatient	\$400 - \$600

Source: Shepard and Vargas, 1994, p.11.

Within the period of 1995/96, Cuba had more than 25,000 patients (UNCTAD Secretariat, 1998). By 1996, the country had treated 7,000 foreigners from 60 different

countries for specialized care, such as treatment for vitiligo, psoriasis, and retinosis. Other services include neurologic rehabilitation, clinical care for HIV-positive patients, and plastic surgery—the fastest growing area. In 1995, health tourism in Cuba netted \$23 million in profits (Brenzel and Le Franc, 2000).

The institution responsible for health tourism is SERVIMED, a state-run company which relies on the infrastructure of a network of hospitals and 42 resort centers (Latin American Weekly, 1997). SERVIMED markets health tourism through travel agencies, private clinics, and word-of-mouth (Shepard and Vargas, 1994). Table 4 shows that the principle origin of patients is South America (83% of all patients in 1994). European patients account for 6.3% of total health tourists; and, North American patients represent 5.3% of total tourists. Because of the U.S. Embargo, it is not possible to estimate the number of health tourists coming from the U.S. In addition, these figures under-estimate the total number of visitors served, since some patients are admitted to programs after arriving in Cuba.

Table 12: SERVIMED Visitors by Country of Origin (1994)

Country of Origin	Patients	Companions	Total Health Tourists	Percentage Patients
Argentina	850	551	1,401	37.6%
Ecuador	431	43	474	19%
Venezuela	191	127	318	8.45%
Brazil	118	125	243	5.2%
Other South America	286	125	411	12.65
<i>Subtotal South America</i>	<i>1,876</i>	<i>971</i>	<i>2,847</i>	<i>83%</i>
Canada	44	21	65	1.9%
Mexico	78	36	114	3.45%
<i>Subtotal North America</i>	<i>122</i>	<i>57</i>	<i>179</i>	<i>5.3%</i>

Spain	47	40	87	2%
France	36	16	52	1.6%
Other Europe	60	43	103	2.65%
<i>Subtotal Europe</i>	<i>143</i>	<i>99</i>	<i>242</i>	<i>6.3%</i>
Puerto Rico	71	47	118	3.1%
Dominican Republic	48	16	64	2.1%
<i>Subtotal Central American & Caribbean</i>	<i>119</i>	<i>63</i>	<i>182</i>	<i>5.2%</i>
<i>Subtotal Health Tourists</i>	<i>2,260</i>	<i>1,190</i>	<i>3,450</i>	<i>100%</i>
Travel Medicine/Direct Admissions	1,698	1,175	2,873	
TOTAL	3,958	2,365	6,323	

Source: Shepard and Vargas, 1994, p. 9

The growth and strength of the SERVIMED programs will represent an important source of regional competition for the English-speaking Caribbean in terms of developing and establishing health tourism activities. However, since the market for health services in Cuba focuses on specialized care, the CARICOM countries need to focus on development of other niche markets and products.

Jamaica

Jamaica, with an estimated population of 2.5 million people, is a low income country with a GDP per capita of US\$1,510 (PAHO 1999) and national health expenditure about 5% of GDP and private expenditure estimated to be 50% of that expenditure. Most of the overseas care is provided in Florida. Despite its economic problems, Jamaica has sustained a large tourism base accounting for about 30% of its GDP (JAMPRO). In 2000, Jamaica had approximately 2 million visitors, 1.3 million stay overs, and 0.7 million cruise ship visitors. About 60% of tourists originate in the USA, 30% from Europe and 10% from the Caribbean and other countries.

Health Tourism

Jamaica has documented private sector development in health tourism since the late 1980s driven by an interest in the diversification of its tourism product and potential for trade in health services has been researched as part of the overall policy development process for trade in services. However, much of the development has remained relatively fragmented, small scale with most of the progress in the range of wellness services located in the tourism infrastructure. There appears to be a growing interest and activity in the development of spas and complementary healing practices in response to increased demand from the international marketplace.

A major development initiative was undertaken in November 1999 when a workshop on health tourism was convened under the auspices of the University of the West Indies and Ministry of Health, in order to bring together public and private sector interests so that an action plan could be developed for the way forward in Jamaica. Participants included:

- Government: Ministry of Tourism, Planning Institute of Jamaica (PIOJ), JAMPRO (Investment Agency), TPDCO (Tourism Product Development Company Ltd), Jamaica Tourist Board (JTB), Bureau of Standards
- Commercial Private Sector: local investment companies, health insurance
- Selected Private health providers active in the health tourism market

- Regional and international agencies: Caribbean Tourism Organisation (CTO), UWI, PAHO Washington and Jamaica, SERVIMED Cuba

The outcome of the workshop was the identification of key actions needed to support the development of the industry based on the analysis of the potential niches and constraints to development, both in the short and long term. It was agreed that the immediate next step was the establishment of a subcommittee on Health Tourism under the aegis of the Joint Task Force on Health and Tourism. The subcommittee was to be chaired by the Ministry of Tourism. The ToRs for the subcommittee includes:

- Develop policy framework for Health Tourism
- Develop standards and guidelines in line with international standards
- Develop the required regulatory framework
- Collect/review data to determine the inventory of possible marketable services and skills
- Conduct project feasibility studies
- Examine and improve support services and linkages
- Establish a framework policy for malpractice and other insurance, where necessary
- Propose and promote models of private and public alliances that could lead to the establishment of diverse health tourism products
- Develop investment portfolio, with appropriate incentives, to attract overseas investors, particularly those with established brands and to otherwise devise strategies to access equity capital
- Evaluate human resource requirements. Develop and implement HRD policy and strategy to meet required needs
- Monitor and assess impact of model projects
- Assess market trends to determine future directions
- Develop and implement marketing strategies to promote health tourism.

Standing membership on the Subcommittee included the Government agencies active in planning, policy and standards setting in health and tourism with plans to co-opt private sector participation as needed.

Despite the expressed interest and endorsement of the action plan by the participants of the workshop, the subcommittee had not yet been convened by February 2001. Both Ministries of Health and Tourism have undergone significant restructuring and pressures of existing workloads did not allow for new initiatives such as this. However, neither was there any follow up action from any of the other agencies which were nominated to the subcommittee.

All of these agencies lack a focal point for action on health tourism or any technical health capacity. MoH's orientation has primarily been on promoting 'healthy tourism' which involves raising the public health standards of the hotel industry and so to safeguard the visitors' health while in Jamaica. The Health Sector Reform Programme has not considered health tourism as a specific issue, although developing public-private partnerships falls under the Policy and Planning Division. Ministry of Tourism has been focused on developing the sustainable tourism strategy that could have implications for health tourism.

JAMPRO, the investment promotion agency for Jamaica, receives any international health sector investment proposals by the Tourism Promotion Division and depends on MoH to evaluate the technical feasibility of the proposal. To date, there has been no successful health sector investment project started, although one is under consideration.

Many of the participants from the workshop endorsed the usefulness of the workshop in bringing players together to gain exposure to different views and experience. Suggestions for improving follow up included:

- More private sector involvement and leadership
- Less emphasis on planning and more on action
- Early identification of financial resources to support implementation

Private sector providers have continued on their own to provide and expand where possible their range of services based on information shared on a sense from the workshop of increasing demand in the marketplace. They have different incentives and do not see the equity and affordability issues as their concern. They are focused almost exclusively on expanding the local market for their services by attracting the international market.

An interesting departure from this purely commercial aspect is the concept of Community Tourism which is being promoted by the Jamaica Hotel and Tourism Association as an approach and a product which encapsulates a healthy lifestyle vacation package with improving the health of the community in which the package is being delivered. The underlying philosophy is similar to that of sustainable tourism – that tourism as an industry should be based on the assets of the community/location and safeguard these assets for future generations. Astra Country Inn in Mandeville is an example of a hotel who is involved in this approach. They have established programmes for the improvement of the health of the local community and strengthening practical skills to enable them to generate an income from tourism. They have also developed linkages among wellness and clinical providers (like the Menopause Centre, the Dermatology Centre and the Mandeville Hospital) in both the public and private sector and is leading an initiative where visitors go to the local hospital as an integral part of the local attractions. A recent visit by visiting American doctors giving free care to the local community at the hospital resulted from this initiative.

The hospital infrastructure in Jamaica is relatively underdeveloped in the private sector and although there has been some investment in the public hospital infrastructure (for example the Mandeville Hospital is recently built), the public sector is generally not geared to serving a tourist population. It is expected that the Regional Health Authorities will bring a fresh and more business like approach to the running of these facilities, however, the assets have not yet been vested in the RHAs nor have staff moved over to their employment.

The University Hospital at Mona is operating more autonomously under the range of changes at UWI where departments are expected to be more business oriented and to meet defined performance (and income) targets. Where UH has the best potential for treatment and rehabilitation services based on clinical quality, location in Kingston away from the normal tourism destinations of the north coast may be an issue. Potential services that could be marketed more actively include surgical services at the Thwaites private wing and in vitro fertilization (IVF) services in the new Diagnostic Centre for Obstetrics and Gynaecology, the latter already has begun to attract regional clients but

feels it needs to establish certain performance standards before it can market itself actively.

Trade Issues

Of note, the Ministry of Foreign Affairs and International Trade has not been an active participant on any of the recent round of health tourism initiatives. The focus to date has been broadly on intra-regional trade and negotiating liberalization of the CARICOM market and there has been no detailed look at trade in health services specifically.

These broader trade negotiations will have potential effects on trade in health services and the Ministry would be keen to support looking at the following issues:

- Movement of consumers – Jamaicans repatriating after retirement would be a big market for retirement communities as there are many issues now about their safety and absorption back into their communities. Could also look at how to use Mona graduates to build referral network
- Foreign Investment - Remittances is second largest contributor to GDP and there is potential to expand this to creating the right climate for Jamaican networks in US, Canada and UK as potential investors in health
- Movement of professionals – priority area for liberalization as this would allow easier movement for training and upgrading of skills, but would need to explore incremental liberalization in terms of health as it relates to mutual recognition

Dominica

Dominica with an estimated population of 80,000 has a GDP/capita of US\$ 2,990 with a estimated 6.6% of GDP spent on health, of which 40% is private expenditure (PAHO 1999). Most of the overseas care is referred to Martinique or Guadeloupe, Barbados and the USA. Dominica is one of the CARICOM countries aiming to diversify its economic and trade base from agriculture (particularly bananas). In 2000, Dominica had approximately 400,000 visitors, 130,000 stay overs and 270,000 cruise ship visitors. About 60% of tourists originate in the USA, 30% from Europe and 10% from the Caribbean and other countries.

Health Tourism

Dominica has been active in developing its tourism industry over the last ten years, with a significant increase in arrivals in the last two years due to cruise ship visitors. However, the nature of the cruise ship market has exacerbated some of the underlying infrastructural constraints, namely the condition of the road network, development of tourist sites and the capacity of the country to serve large numbers of tourists in terms of transport, food services and entertainment. It is reported that the number of stayover visitors has stagnated, and that occupancy rates in many of the hotels (particularly) the smaller ones are not high.

Some of the constraints to the development of the tourism industry in Dominica will also constrain the development of health tourism on any medium to large scale, and these include:

- Air transport – the inability to handle night landings and no direct access to target markets (UK, USA)
- Road infrastructure - poor condition of existing road network – difficult access to new, bigger airport in North
- Hotel infrastructure in terms of quality and management capacity
- Marketing capacity in terms of funding, international linkages and skills

- Financial investment – capital and recurrent – for the development of the sites, maintenance and staffing until self financing

However, the emerging strategy of developing and marketing Dominica as the ‘Nature Island of the Caribbean’ based on its natural assets, instead of trying to compete with the surf, sea and sand tourism of Barbados and Antigua, does seem to be taking off and has high potential at this time when eco tourism and healthy vacations are fashionable.

The Ministry of Tourism has made a strong case for a hyperbaric chamber to be procured for the Princess Elizabeth Hospital, but neither the MoH nor the Hospital Management is aware of how the recurrent budget will be allocated for the new service. The cost justification of the chamber was based on the risk to the diving industry, not on the annual caseload or any financial modeling that showed that it could be a self-financing service. Plans have not been made for the training of hospital staff to run the service, regular updating (as they only now transfer a handful of cases to Guadeloupe), or maintenance of the chamber to ensure a smooth commissioning of the service and the provision of a safe, high quality service.

Where this is not a pure example of health tourism, it does bring out the need to have a range of locally available services for tourists who visit the island and engage in relatively higher risk activities than the ‘surf, sea and sand’ tourist. It is, however, an additional cost to the infrastructure that is needed by the tourism industry to thrive, and a similar case could be made for the need for emergency evacuation from the more difficult tourist sites (the falls, the Boiling Lake) in the event of a serious injury then at least stabilization capacity at PEH and evacuation off island as necessary.

Dominica is home to the offshore medical school, Ross University, and is locally referred to as ‘medi-tourism’ – one of the pillars of its economy. This medical campus has been in Dominica for nearly 22 years and has grown to a current enrollment of 780 students. The school is duty exempt, but does pay some taxes although neither the administration nor the MoH is aware of the details. They were also tax exempt in the inception, but that period has now lapsed although there was some speculation that it was under negotiation. Since the financial headquarters is in New York, no financial management is performed in Dominica thereby limiting access to financial data during the site visit. The administrative staff are not even certain the exact tuition fees. The

University therefore contributes economically through the businesses and livelihoods that serve the students and staff of the School. Most of the full time staff are expatriate, with local doctors providing part time input through lectures. The Dean of the School is Dominican.

Ross University has recently requested the Medical Board of Dominica to accredit the University, as this has become a requirement for the students to re-enter the USA. The Medical Board is considering the request as they feel that it adds to the reputation of the country and the local profession. However, there is the question of the internal capacity of the Board to manage such a function. Most of the input to the Board is voluntary, although one presumes that a charge will be levied on the University for the service. The University currently does not have any clinical linkages with the PEH. Although the MoH is meant to oversee the presence of the School in a regulatory sense, there is no joint mechanism for review of credentials of staff or routine monitoring of the programme internationally.

Dominica boasts of a strong tradition of herbal medicines and traditional healing practices and lays claim to the oldest living person in the world. Nature tourism and eco-tourism have been available in Dominica before it was fashionable, and the country is interested in moving forward with that and the marketing of their natural spas – the sulphur springs which traditionally have been known for their healing properties. Neither the Ministry of Health nor Tourism has embarked on any programme for developing a framework for monitoring activity or standards or care for this industry. While it is felt it must be a good thing to add to the range of tourism products, the issue of consumer protection and liability has not entered the discussion.

Trade issues

Movement of consumers: Dominica would like to encourage the expansion of Ross University and some this as key to the broader development of health services for tourists in the future. It would also like to explore the development of a strategy to attract retirement communities to the island, similar to the Montserrat situation before the eruption. It recognizes that this will need expanded health services capacity.

Foreign Direct Investment: Just as they have been successful in keeping Ross University in Dominica, there is a realization that something will need to be done to attract similar investment for the expansion of the tourism industry and possibly the health tourism market.

St Lucia⁴⁴

St Lucia has an estimated population of 137,000, a GDP/capita of US\$ 3,370, with an estimated 5.0% of GDP spent on health (48% is private expenditure (PAHO 1999)). Most of the private overseas care is obtained in the USA. Some is also sought in Barbados and Trinidad and Tobago. Tourism and agriculture are the two largest economic sectors.

Health Tourism

St Lucia has the largest private sector in terms of number of practitioners and the largest private inpatient facility in the OECS, excluding Barbados. Doctors are contracted by the government to work in Victoria Hospital and since most are not civil servants, they also have large private practices. Tapion Hospital is owned by a group of local business people and a group of doctors, and is managed by an executive board of which the Chair and vice chairman are both doctors. A full range of services are provided by Tapion, including diagnostic, general surgery, obstetrics and gynaecology, internal medicine including cardiology and a visiting cosmetic surgeon.

Tapion contracts out all of the services in the hospital except for pharmaceutical services which is managed in-house. The hospital rents space to an American company (Island Dialysis) to provide dialysis services, and is negotiating another contract for cancer services and a pain treatment centre with a French provider. Tapion does not view this as a joint venture, but more of a landlord-tenant arrangement. It does not see itself sharing any of the risk or liability with the provider. It does no joint planning with the public sector and has not tried to negotiate any contract with the government to provide services out of concern that Tapion would not get paid. Tapion has not worked through the NDC or the MoH to establish its operations.

⁴⁴ The OECS Trade Policy Project is being managed out of St Lucia.

Outpatient services are provided on the same basis, where doctors rent office space from Tapon Hospital and have admitting privileges to the hospital. The hospital was set up to provide services to St Lucians, and has not specifically developed services or is marketing itself for health tourism, although this had been considered in the first stage of development of the hospital. There has been sufficient caseload without going for the health tourism market, although the new cancer treatment centre is expected to be marketed regionally by the provider group.

The MoH is not actively supporting any activity with respect to health tourism in terms of joint planning with any of the tourism agencies, although it is participating in the CAREC project on improving health standards in the hotel industry through the environmental health team. Victoria Hospital provides some emergency care to visitors and systems are now being set up to track this caseload as indications are that the utilisation rate is increasing as well as the complexity of the cases. The MoH has recently embarked on a reorganisation of the Central Headquarters to strengthen the policy and planning capacity and is also planning a new 200 bed Victoria Hospital to be co-financed by the European Commission. The current plans do not include private sector partnerships either local or international or provision for the use of the new facility by the private sector.

In terms of health tourism activity, Le Sport in the north of the island has been documented in several previous studies on health tourism as a premier spa resort in the Eastern Caribbean and of international ranking. The hotel is locally owned and has expanded operations to two facilities in St Lucia and one in Grenada. The approach is to provide a full range of healing therapies and healthy activities together with a soothing ambience and meals geared to a healthy lifestyle. The package is all-inclusive so as to encourage the guests to avail themselves freely of the services provided. Other hotels also market spa products, but they are generally not considered to be of the same caliber and focus as Le Sport.

Trade Issues

The OECS Trade Policy Project was developed in response to a request from the Heads of the OECS to Canadian International Development Agency (CIDA) and is

approximately five years from October 1999 to Dec 2004, with the detailed design phase completed in March 2000. Project activities are being delivered through a mixture of short and long term technical assistance, training and overseas attachments using an iterative process with the Project Manager working in consultation with the OECS and the member states.

The project purpose is to strengthen the OECS capacity in three areas:

- the development and maintenance of an OECS international trade strategy
- to meet obligations under regional and international trade agreements
- to participate effectively in international trade negotiations

If the project is successful, then it is expected to see increased participation of the OECS in reciprocal rules-based trade agreements and increased trade and investment from greater participation in the global market economy. In the longer term, the capacity of the OECS sub-region to participate and compete in the global economy will be improved.

Project outputs include:

1. Sub regional trade policy framework prepared
2. Strengthened capacity of national and sub-regional public and private sector institutions to develop trade policy
3. Priority obligations under trade agreements implemented
4. Strengthened support role for OECS Secretariat in meeting member state obligations
5. OECS strategy for trade negotiation prepared
6. Strengthened trade negotiation support from the OECS Secretariat
7. Staff trained in trade ministries, OECS Secretariat and private sector associations.

The project sees that one of the biggest problems in moving the trade agenda forward is the segmentation and dissecting of the issues by country, by sub region, by sector interest (public and private), by industry (health, IT, financial etc). The fact is that 78% of OECS trade is already in services and what is needed is a more holistic approach in looking at how to move forward rather than trying to recapture lost markets and old relationships.

In the first year, the project has focused on sensitising the OECS countries through a series of workshops involving both private sector and trade officials on: 1) the content and implications of GATS; 2) the role of services in the OECS; and, 3) the value of trade to the economies of the OECS. These initial workshops are being followed up by working sessions looking at particular service areas, based on country priorities which were identified. Participants are being asked to work on strategies for developing trade in their service area. St Lucia had a working participant from Tapion Hospital in one of these sessions.

Key issues that have been highlighted in the project include:

- Communication among the various players: wide participation is invited in the workshops but information is still being compartmentalised. Clarity is need in terms of who deals with what and how to involve and engage the private sector so that they can begin to take a bigger role in shaping public policy;
- Lack of awareness and knowledge on:
 - What is available locally and regionally – an inventory of services and resources
 - The issues of development beyond the domestic agenda
 - The legislative context needed to compete internationally
 - The big picture in terms of benefits and pitfalls.
- The availability and use of incentives not only to attract capital but for technical/management services. This requires being able to negotiate on the basis of strategy not short term gain;
- Ministries of Foreign Affairs/Trade are the coordinating bodies in the countries for trade relations and international negotiation but their effectiveness is constrained by the lack of a high level secretariat for implementation.

If the issue is limited resources, then the way forward must look at how these resources can be optimized outside of the normative boundaries that comprise the politics and culture of the region and subregion.

2.3.8 Trinidad and Tobago

Trinidad and Tobago with an estimated population of 1.4 million, has a GDP/capita of US\$3,370. An estimated 4.7% of GDP is spent on health, of which 55% is private expenditure (PAHO 1999). Most of the overseas care is provided in the USA, and to a lesser extent Venezuela, Canada and the UK. Tourism is a relatively small economic sector because of the dominance of the energy industry; but tourism is the largest economic sector for Tobago with a population of about 50,000.

Health Tourism

The MoH is not actively involved in specific initiatives on health tourism or trade in health services issues. The focus has been in the implementation of the Health Sector Reform Programme which aims to improve the quality of health services available to the population and using the strategy of the separation of the government's provider function from its 'purchasing' function. The HSRP comprises of 4 key components:

- Establishment of 5 Regional Health Authorities to manage and provide health services to the general population in keeping with national policy
- Reorganisation of the MoH to strengthen its role in policy and regulation
- Modernisation and rationalization of the public provider network to improve efficiency and quality of care in a sustainable manner
- Continued work towards the implementation of a national health insurance system

To date, the RHAs have been established, management teams appointed, physical assets have been transferred but transfer of staff to the employment of the RHAs has been delayed. The latter has had a significant effect on the ability of the RHA to manage the services and there have been a series of staffing crises with respect to conditions of service, particularly salary, for both nurses and doctors. Shortages of nurses remains a

particular concern and Trinidad and Tobago has become one of the key destinations for nurse recruitment.

From the MoH's perspective, work has been ongoing in the Directorate of Quality Management in the development of a quality framework including new legislation, licensing and accreditation issues and establishing mechanisms for monitoring customer satisfaction. The Health Services Act has been drafted to replace the current Hospitals Act and to establish the framework for monitoring quality in all health facilities, including laboratories, diagnostic centres, outpatient clinics and day surgery centres which have been growing in an unregulated fashion to date. Both RHA and private facilities will be governed by this law. Work is also needed to modernize the Public Health Act and for improving professional self regulation. The MoH is also supporting the CAMC initiative for the standardization of medical examinations similar to what has happened for nursing in the Caribbean, so that it will be easier for the movement of CARICOM nationals to work in Trinidad and Tobago.

The MoH expressed concerns about the effect of health tourism on emphasizing the shift of the labour force away from serving the general public towards more elitist groups (i.e. those able to pay higher prices) and also increasing the demand for more expensive services. There were perhaps opportunities to balance this through the contracting of private services on behalf of the population, but many of these more highly specialized or esoteric surgeries are limited in the public domain by the simple absence of it, and mechanisms for controlling the introduction of technology (and replication of expensive resources in the private sector to the detriment of quality and sustainability) are not yet in place. Work on national health insurance would also be a key instrument in ensuring equity and re-balancing distribution of financial resources for health and the impact of health tourism would need to be included in the modeling.

Since the late 1980s and early 1990s, the Government of Trinidad and Tobago had embarked on initiatives to encourage the sharing of health services with neighbouring islands provided by the Eric Williams Medical Sciences Complex (EWMSC). However, EWMSC is still not fully commissioned and therefore has operational constraints in openly marketing itself to the region. It does provide care to individuals from Guyana, Grenada, St Kitts, St Lucia and Barbados on a self referral basis or on a government

referral. The link is usually by referring physician. The operational constraints of EWMSC is related to the ambiguity of the employment status of the staff who work there, and the inability of the government to fund the proper start up of the facility. For EWMSC to be a centre of excellence for hospital services, it must provide a full range of support services including the basic hospital specialties before it can provide in a competitive way tertiary or sub specialties, which in turn can be marketed on the export market. Much of the referral now is done in the same pattern of utilisation that exists in the private sector throughout the Caribbean, on a piecemeal basis but without the proper support framework if the patient becomes complicated.

EWMSC offers a cardiology service in a joint venture arrangement with a local company who in turn works collaboratively with a European partner. When the programme started, the cardiothoracic surgeon would come down on a regular basis to do cases that were booked and evaluated by the local team. In recent years, the programme has suffered from the loss of nursing staff for immediate post operative care, so now the visiting team also comprises one or two cardiac intensive care nurses who remain for about two to five days post operation. Some training is also being provided to local nurses. A similar interventionist service is also being provided in a private hospital in the North with a surgeon (originally Trinidadian) from the USA, and there are plans for the construction of a new facility specializing in cardiac treatment.

The Complex has also tried over the years to negotiate a contract with an international partner to set up radiotherapy services as the National Health Plan calls for the transfer of radiotherapy services and the establishment of a cancer treatment centre at Mt Hope. However, this has not been successful because of the lack of the ability of EWMSC to complete the negotiation in time and/or to properly evaluate the international partner. Coincidentally, the North West RHA has negotiated a CT Scan service at Port of Spain General Hospital in a joint venture arrangement with Atlantic Medical.

The private sector anecdotally reports seeing foreign patients on a fairly regular basis, primarily in the sub specialties – ENT, Ophthalmology, cosmetic surgery, orthopaedics – the majority of which are from Guyana, Grenada and Antigua. Like the foreign patients who go to EWMSC, there is no active marketing being done, but most patients self refer (because of personal reference) or are sent by a referring physician. Most of the private

facilities are owned by doctors. EWMSC management speculates that this could be one of the contributing reasons why to date the Complex remains uncommissioned although the doctors would argue that is purely bad design and planning.

The MoH collates some data on private sector activity, but is aware that there is a significant level of underreporting and certainly no statistics about treatment of foreign patients. The licensing of hospitals is currently based on adhering to good public health standards rather than to any evaluation of quality of care. There are an estimated 1,200 – 1,400 doctors working in the country about 500-600 general practitioners.

There are no specific incentives for trading in health services or to stimulate the health tourism market. The Tourism and Industrial Development Company of Trinidad and Tobago Ltd (TIDCO) has no specific mandate for health sector investment, although is set up to be the entry point for foreign investment inquiries in the country. It can provide general information about the establishment of foreign companies and investment incentives that generally can apply to health. They have not been involved with any projects to date on health tourism or more general trade in health services. In spite of this lack of specific incentive programme, there is a sense that there is an increasing number of joint venture activities in health – but usually on a physician-to-physician basis, without the knowledge of the MoH or TIDCO or Ministry of Trade.

Most of the activity in tourism is focused on Tobago, and there is a range of incentives available and a Tourism Act formalizes these incentives is pending. TIDCO acts as a facilitator and catalyst for private sector investment in Tobago, but neither TIDCO nor the Tobago RHA nor the Tobago House of Assembly has considered to date the potential for health tourism or even the impact of the use of local health services by tourists in the planning of the new Tobago Hospital. For example, the newly completed Tobago Hilton Hotel and Tobago Plantations are planning a spa facility in Phase 2 and possibly including cosmetic surgery. No discussions have been held about a potential partnership between the hotel and the Tobago RHA in terms of using the new hospital. The Tobago RHA has made provisions in the design of the facility for the possibility of expansion for use by the private sector but to date no discussions have been held with the Hotel Association about this possibility.

Regional initiatives related to Health Tourism

CAREC, in collaboration with **CAST** (Caribbean Action for Sustainable Tourism), is implementing a project on Healthy Tourism with the overall goal to improve the quality and competitiveness of the tourism industry. The project purpose or end of project impact will be the establishment and dissemination of quality standards, systems, and registrations designed to ensure healthy, safe and environmentally conscious products and services for guests and staff. The countries involved include: OECS, Bahamas, Barbados, Jamaica and Trinidad and Tobago.

A 'joint venture' agreement between **CAST** and **CAREC** has been drawn up and the project will run for 3 years from 1999-2002. A Project execution unit (PEU) has been established in **CAREC** and is accountable to a Steering Committee comprising public and private sector representatives jointly nominated by **CAST** and **CAREC**. The project is being co-funded by the participating countries and the IDB through the Multilateral Investment Fund (MIF), with the intention that the longer term sustainability will be addressed through the collection of fees from hotels and other establishments for training, audits, inspections and registration.

One of the biggest hurdles in the project startup period was getting the cooperation of the hotels in the process and to build understanding of the longer term benefits to the industry. Many of the smaller hotels felt that this would mean more work and higher costs for them, particularly in the short term and could not see how this would help them to compete. Others felt it was going to be another bureaucratic imposition by the MoH in terms of adhering to standards. The larger and more progressive hoteliers who had standards in place welcomed the project and could see the benefit to the industry in the longer term, particularly some form of registration or accreditation which would be recognized by tour operators.

The ILO Caribbean Office, based in Trinidad, is working closely with governments, employers and trade unions in the fields of employment creation, human resource development, social security and social dialogue. The ILO has not been involved with specific activity related to health tourism or analysing the labour situation in the health sector. However, it does have background and interest in the tourism sector and is

embarking on a study to lay the basis for its involvement in the tourism sector and to formulate guidelines for activities in the next 2 years.

The ILO feels that decent jobs, less combative labour relations and HRD will contribute to productivity and sustainability of the sector. They feel that a regional research programme is required (in synergy with CTO and UWI) which will include regular statistical monitoring, development of models to look at economic gain as well as cultural, social and environmental impacts. The output of this research programme would be used to design and reach social consensus on strategies, policies, programmes and instruments that would allow countries to steer their tourism industry towards sustainable development.

The background study is to be finished around April 2001 and will look at available data on tourism and their location regionally and more in depth six country studies including Bahamas, St Lucia, Barbados, Jamaica, Guyana and Trinidad and Tobago. The output will be used:

- to support the planning of the Joint ILO/CTO tripartite meeting in April 2001 on “Labour in the tourism sector”
- to develop an approach to the tourism sector in the region
- develop cooperation and synergies with other regional and international organisations including CTO, UWI and CDB
- finalise input for the ILO Caribbean Office meeting on the hospitality industry in April 2001

Trade issues

A potential local private sector investor in health, in describing their experience of developing the project identifies the following internal barriers:

- Lack of incentives for investment in the health sector
- Poorly developed business and management perspective among health providers
- Fragmented framework for investment
- Lack of transparency in the process for approval of appropriate sites

- Lack of support from the public sector in terms of facilitating entry, joint planning and defining standards
- Lack of health specific management skills, this would need to be perhaps sourced externally
- Limited capacity to see larger implications of globalisation/liberalization of health market
- Control of the local market by doctors is a constraint in terms of efficiency.

Another view of investment is provided by the International Finance Corporation (Private Sector Investor of the World Bank Group) which has set up a small office in Trinidad covering the Caribbean. The IFC is capable of financing relatively large projects in the private sector and has instruments which are generally not available in the commercial banking sector. Although the source of financing is cheaper, the lending rates are compatible with the commercial sector so as to compete fairly. IFC is not currently funding any health sector initiatives, although considering tourism proposals.

The key characteristics of a project that will be considered by IFC include:

- Clear definition of the market
- Technical and managerial capacity to implement the project
- Financial analysis demonstrating the longer term feasibility of the venture.

There are no particular incentives or special concessions for the social sector, including health, but IFC considers that the technical support that can be offered through its Washington based team would be invaluable to improving the quality of many of the investment ventures in the Caribbean. Clearly, capital and access to affordable capital and supporting investment incentives are important in attracting investors interest, but in the Caribbean they are not critical success factors for implementation. Often the viability of the project is undermined by the lack of technical and managerial capacity to run the venture and for large projects, this must be addressed e.g. by including the cost of a management contract with an international firm, joint venturing with international partners on the investment.

<i>APPENDIX 2. GATS GNS, CPC prov and CPC V1.0</i>					
GATS GNS*	CPC prov	Description		CPC V1.0	Description / Detail
	93	Health and social services	931 - Human health services 932 - Veterinary services 933 - Social services	93	Health and social services
	931	Human health services	9311 - Hospital services 9312 - Medical and dental services 9319 - Other human health services	931	Human health services
8. Health related and social services (other than those listed under 1.A.h-j.) A. Hospital services 9311 B. Other human health services 9319 (other than 93191) C. Social services 933 D. Other	9311	Hospital services	93110 - Hospital services	9311	Hospital services

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	93110	Hospital services	<p>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. Hospital services comprise medical and paramedical services, nursing services, laboratory and technical services including radiological and anaesthesiological services, etc.</p> <p>Exclusions: Services delivered by hospital out-patient clinics are classified in subclass 93121 (General medical services) or 93122 (Specialized medical services).</p> <p>Dental services are classified in subclass 93123.</p> <p>Ambulance services are classified in subclass 93192.</p>	93110	Hospital services
1. Business services -A. Professional services- Medical and dental services 9312	9312	Medical and dental services	<p>93121 - General medical services</p> <p>93122 - Specialized medical services</p> <p>93123 - Dental services</p>	9312	Medical and dental services

	93121	General medical services	Services consisting in the prevention, diagnosis and treatment by doctors of medicine of physical and/or mental diseases of a general nature, such as consultations, injections (limited and/or periodical), physical check-ups, etc. These services are not limited to specified or particular conditions, diseases or anatomical regions. They can be provided in general practitioners' practices, and also delivered by out-patient clinics, attached to firms, schools, etc.	93121	General medical services
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	93122	Specialized medical services	<p>Diagnosis and treatment services by doctors of medicine of diseases of a specific nature, delivered in a specialists' practice or health institution (including hospital in-/out-patient clinics).</p> <p>These services are defined as those limited to specific or particular conditions, diseases or anatomical regions (except dental services), such as medical services for the following: nervous system; eye; ear, nose and throat; respiratory system; circulatory system; digestive system; hepatobiliary system and pancreas; musculoskeletal system connected tissues; skin, subcutaneous tissue and breast; endocrine, nutritional and metabolic diseases and disorders; kidney and urinary tract; male reproductive system; female reproductive system; pregnancy, childbirth and puerperium; newborns and other neonates; blood and bloodforming organs; myeloproliferative disorders; infectious and parasitic diseases; mental diseases and disorders; substance use and substance induced organic mental disorders; injuries, poisonings and toxic e</p>	93122	Specialized medical services
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	93123	Dental services	<p>Diagnosis and treatment services of diseases affecting the patient's teeth or aberrations in the cavity of the mouth, and services aimed at the prevention of development of dental diseases, including dental surgery even when given in hospitals to in-patients.</p> <p>These dental services can be delivered in health clinics, such as those attached to schools, firms, homes for the aged, etc., as well as in own consulting and operating rooms. It concerns services in the field of general dentistry, such as routine dental examinations, preventive dental care, treatment of caries, etc.; orthodontic services, e.g. treatment of protruding teeth, crossbite, overbite, etc.; services in the field of oral surgery; other specialized dental services, e.g. in the field of periodontics, paedodontics, endodontics and reconstruction.</p>	93123	Dental services
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8. Health related and social services (other than those listed under 1.A.h-j.) B. Other human health services 9319 (other than 93191)	9319	Other human health services	93191 - Deliveries and related services, nursing services, physiotherapeutic and para-medical services 93192 - Ambulance services 93193 - Residential health facilities services other than hospital services 93199 - Other human health services n.e.c.	9319	Other human health services
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<p>1. Business services A. Professional services -Services provided by midwives, nurses, physiotherapists and para-medical personnel 93191</p>	<p>93191</p>	<p>Deliveries and related services, nursing services, physiotherapeutic and para-medical services</p>	<p>Services such as supervision during pregnancy and childbirth and the supervision of the mother after birth. Services in the field of nursing (without admission) care, advice and prevention for patients at home, the provision of maternity care, children's hygienics, etc. Physiotherapy and para-medical services are services in the field of physiotherapy, ergotherapy, occupational therapy, speech therapy, homeopathy, acupuncture, nutrition instructions, etc.</p>	<p>93191</p>	<p>Deliveries and related services, nursing services, physiotherapeutic and para-medical services</p>
	<p>93192</p>	<p>Ambulance services</p>	<p>General and specialized medical services delivered in the ambulance.</p>	<p>93192</p>	<p>Ambulance services</p>

	93193	Residential health facilities services other than hospital services	Combined lodging and medical services not carried out under the supervision of a medical doctor located on the premises.	93193	Residential health facilities services other than hospital services
	93199	Other human health services n.e.c.	Services in the field of: morphological or chemical pathology, bacteriology, virology, immunology, etc., and services not elsewhere classified, such as blood collection services.	93199	Other human health services n.e.c.
1. Business services A. Professional services i. Veterinary services 932	932	Veterinary services	9320 - Veterinary services	932	Veterinary services
	9320	Veterinary services	93201 - Veterinary services for pet animals 93209 - Other veterinary services	9321	Veterinary services for pet animals
				9322	Veterinary services for livestock
				9329	Other veterinary services

	93201	Veterinary services for pet animals	Animal and veterinary hospital and non-hospital medical, surgical and dental services delivered to pet animals. The services are aimed at curing, reactivating and/or maintaining the health status of the animal. Included are hospital, laboratory and technical services, food (incl. special diets), and other facilities and resources.	93210	Veterinary services for pet animals
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	93209	Other veterinary services	Animal and veterinary hospital and non-hospital medical, surgical and dental services delivered to animals other than pets (incl. zoo animals and animals raised for their fur or other products). The services are aimed at curing, reactivating and/or maintaining the health status of the animal. Included are hospital, laboratory and technical services, food (incl. special diets), and other facilities and resources.	93220	Veterinary services for livestock
				93290	Other veterinary services
8. Health related and social services (other than those listed under 1.A.h-j.) C. Social services 933	933	Social services	9331 - Social services with accommodation 9332 - Social services without accommodation	933	Social services

	9331	Social services with accommodation	<p>93311 - Welfare services delivered through residential institutions to old persons and the handicapped</p> <p>93312 - Welfare services delivered through residential institutions to children and other clients</p> <p>93319 - Other social services with accommodation</p>	9331	Social services with accommodation
	93311	Welfare services delivered through residential institutions to old persons and the handicapped	<p>Social assistance services involving round-the-clock care services by residential institutions for the aged and the physically or mentally handicapped, including the blind, deaf and dumb.</p> <p>Exclusions: Education services are classified in division 92.</p> <p>Combined lodging and medical services are classified in subclass 93110 (Hospital services) if under the direction of medical doctors, and in subclass 93193 (Residential health facilities services other than hospital services) if without supervision by a medical director.</p>	93311	Welfare services delivered through residential institutions to elderly persons and persons with disabilities

	93312	Welfare services delivered through residential institutions to children and other clients	Social assistance services involving round-the-clock care services by residential institutions to children and other clients, e.g. social services by orphanages, homes for children in need of protection, homes for emotionally disturbed children, homes for single mothers, and other social rehabilitation services.	93319	Social services for orphanages, homes for children in need of protection or with emotional impairments. Homes for single mothers.
	93319	Other social services with accommodation	Social assistance services involving round-the-clock care services by residential institutions, e.g. social work provided by juvenile correction homes and rehabilitation services (not including medical treatment services) for people addicted to drugs or alcohol.	93319	Juvenile correction homes; rehab services for persons with alcohol or drug dependence (not including medical treatment); other social rehab services with accommodation

	9332	Social services without accommodation	<p>93321 - Child day-care services incl. day-care services for the handicapped</p> <p>93322 - Guidance and counselling services n.e.c. related to children</p> <p>93323 - Welfare services not delivered through residential institutions</p> <p>93324 - Vocational rehabilitation services</p> <p>93329 - Other social services without accommodation</p>	9332	Social services without accommodation
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	93321	Child day-care services incl. day-care services for the handicapped	Social services by non-residential institutions consisting in providing day-time shelter and elementary, playlike teaching to small children (day-care services) in nursery schools, including day-care services for the handicapped.	93321	Child day-care services
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	93322	Guidance and counselling services n.e.c. related to children	Guidance and counselling services not elsewhere classified delivered to individuals and families, generally the children's parents, in their homes or elsewhere. Such services may deal with behavioural, educational and other problems related to children, e.g. broken-home problems, school problems, development problems, prevention services of cruelty to children, crisis intervention services, adoption services, etc.	93322	Guidance and counselling services n.e.c. related to children
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	93323	Welfare services not delivered through residential institutions	Welfare services not including lodging services, e.g. eligibility determination services in connection with welfare aid, rent supplements and food stamps, old age visiting services, household budget counselling services, and other community and neighbourhood services.	93323	Welfare services without accommodation
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	93324	Vocational rehabilitation services	<p>Vocational rehabilitation services for handicapped or unemployed persons, where the social assistance component is predominant.</p> <p>Exclusion: Vocational rehabilitation services where the education component is predominant are classified in division 92 (Education services).</p>	93324	Vocational rehabilitation services
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	93329	Other social services without accommodation	Other social services not including lodging services, e.g. marriage guidance services, guidance services delivered to persons on parole or probation, social assistance services to disaster victims, refugees and immigrants including shelter services.	93329	Other social services without accommodation

* GATS Services Sectoral Classification GNS/W/120
 Sectors and sub-sectors Corresponding provisional CPC 104

- 1. Business services
 - A. Professional services
 - h. Medical and dental services 9312
 - i. Veterinary services 932
 - j. Services provided by midwives, nurses, physiotherapists and para-medical personnel 93191

- 8. Health related and social services
 (other than those listed under 1.A.h-j.)
 - A. Hospital services 9311
 - B. Other human health services 9319 (other than 93191)
 - C. Social services 933
 - D. Other

APPENDIX 3. COUNTRY VISITS

Introduction

The following country reports reflect the outputs of short scoping visits to six CARICOM countries which were selected because the team knew that there was some health tourism activity or that there may be interest in moving forward in this group of services. These countries included:

Barbados

Bahamas (29 Jan - 1 Feb)

Jamaica (22 Jan - 28 Jan)

Dominica (14 Jan – 17 Jan)

St Lucia (17 Jan – 18 Jan)

Trinidad and Tobago (interview throughout the study).

To the greatest extent possible, a meeting schedule was arranged in advance, although given the informal nature of the exercise, this very much depended on the quality of the initial contact in the country and the availability of persons during the time of the visit. The timing for St Lucia proved difficult, but we were able to talk with the private sector provider and the OECS Trade Policy Project. It was not possible within the resources of the project to make a return visit.

Letters of introduction, the Terms of reference, and an indicative list of questions and who could be involved, were distributed in advance.

There was a variable response, but in general, once people engaged in the discussion, information was willingly shared and issues explored.

Each country report is followed by a list of persons seen, the majority were by personal interview and only a handful were phone conversations. Appendix 4 lists relevant documents that may be useful

references for countries who move forward on the findings of this report.

Bahamas Country Visit

Public Sector Views

Ministry of Health

Has recently embarked on an extensive HSRP with the establishment of the Public Hospitals Authority and the re-organisation of the MoH. Health Tourism as an activity area is geared towards ensuring access to local services by tourists in case of minor injury and illness and to improve the standards of public health and sanitation in the hotel industry.

Statistics are kept for government facilities and now beginning to look at private sector activity. Government expenditure is about \$140 million and it is estimated that this represents about 50% of total expenditure. Of the estimated \$140m out of pocket expenditure, about 50% of that is spent overseas, mainly in Miami.

Examples of health tourism activity in Bahamas include: hotel spas and treatments; Renal Clinic (dialysis unit for tourists); Cancer treatment Centre in Freeport; Doctors Hospital (largest comprehensive in patient facility on Grand Bahamas). Doctors Hospital is currently opening a new clinic in the West of the island catering to wellness products and geared to the tourism market. The MoH is planning to have 3 mini-hospitals in the family islands and this may have some potential to support retirement communities on these islands.

Where the benefits of health tourism as a industry or sub-industry are attractive, the MoH is concerned about the capacity to monitor the quality of care in these facilities, and of some concern would be the international reputation of the Bahamas if there is not some stronger form of regulation. For example, the MoH was not actively involved in the approval of a cancer treatment centre in Freeport, but the HIU noted a sudden rise in the number of deaths due to cancer registered in Freeport. An investigation by the MoH resulted in the temporary closure of the facility, but no decisions were made about how to handle vital statistics recording

since. It was known that the Centre would be treating foreign patients with drugs not yet approved by FDA (but it was not known if this meant for legitimate or bureaucratic reasons), and that patients would be relatively high risk due to the underlying pathology. How to control access by local residents is another important issue.

The recently launched National Health Services Strategic Plan intends to improve the regulation of the sector through the strengthening of regulatory councils – for doctors, nurses, health professionals, facilities, pharmaceuticals, managing the introduction of technology and improving the quality management capacity of the system. Activity related to tourism involves implementation of a programme for Tourists Health in which strategies for reducing injuries and ensuring visitors' safety in food, traffic and water sport are strengthened in order to contribute to the protection of the tourism industry.

Princess Margaret Hospital

PMH is Bahamas main public hospital with 434 beds of which 31 are private-ward beds. PMH provides a full range of general and speciality services to the local population. Also buying services with Doctors' Hospital e.g CT scans and cardiothoracic surgery. PMH does not have a high level of utilisation by tourists, most go to the private sector for care. Examples of health tourism services on the islands include dialysis, spas in the hotels and some herbal traditional medicine practice.

There are pending plans for the redevelopment/modernisation of PMH but to date there has been little consideration given to the potential of the health tourism market or joint venturing with private sector (national or international).

Sandilands Rehabilitation Centre (SRC)

SRC provides geriatric care (130 beds) and psychiatric care (352 beds) as well as an inpatient drug abuse treatment programme. Not aware of any interest in

serving visitor population, although the proximity to the US, the natural ambience of the Bahamas and privacy issues are good assets on which to build a substance abuse treatment programme. However, the US clients would be more informed, litigious and demanding in terms of facilities and standards and Bahamas does not have the systems or range of skills to support that clientele. Medical Liability would be a key issue, rather than medical insurance as many plans would not cover addiction programmes outside the US.

Ministry of Tourism

Bahamas recorded 4.2 million tourist visits for 2000, 2.0 million stopover and 2.2 million cruise ship. About 85% of visitors are American, and of the remaining 15%, 7-8% European, 5-6% Canadian and other nationalities about 1%.

Sustainable Tourism strategies are being introduced in terms of protection of the environment. It was difficult at first to get people to see and agree that it was needed but there is increasing support. This is being led by the BEST commission in the Office of the Prime Minister. Financial incentives for capital investment in hotels provided through the Hotels Encouragement Act and supporting regulations and managed by the OPM.

The tourism product is based on the following: climate, high quality of beaches and water, proximity to the US and variety of hotel products. 4 major facilities have built spas – Sandals, Atlantis Resort, British Colonial Hilton, the Lucayan. Not actively involved with MoH or other health providers in the development of health tourism although the potential has been discussed. Health tourism services being currently provided include: dialysis, complementary healing centres e.g. the Yoga Retreat on Paradise Island, anti-aging institute; cosmetic surgery at Lyford Cay – American doctors fly in to do list, based on referral system in the USA, not marketed by the Bahamas.

Although not included in the Tourism Plan, a potential product for the Bahamas could be the retirement community concept, as there are many visitors who have their second home here. Particularly in the smaller islands, their presence adds

economic vitality and opportunity for jobs. Their entry is facilitated by the International Persons Landholding Act and Home Owners Residence Card which is renewable annually (under the Director of Immigration). Although no data is analysed by age profile, this could be further explored although anecdotally, health care is a concern for these persons as they get older, and often they would sell their house as they get older and less comfortable with the risk.

The Ministry of Tourism could support health in developing of a product and promotion and the MoH would cover standards, quality of care and accreditation issues.

Ministry of Foreign Affairs

The potential for health tourism has been considered as it relates to establishing:

- offshore medical centres which are essentially self contained - bringing its own customers and staff, responsible for marketing itself and accountable in Bahamas through licensing mechanisms;
- Offshore medical schools along similar lines
- Developing a whole island as a 'spa' based on a wellness concept moving towards differentiating a product and incorporating it to the spa pioneers (complementary and inclusive of them).

However, there are recognized and perceived difficulties with these models as it relates to health rather than a tourism product – which include:

- The services must benefit the local population by stimulating the local industry and networking - therefore how to manage the interaction of these offshore medical centres and can they really be self contained?
- More in depth cost benefit economic analysis of such a model, not just about more income generation
- The capacity to manage quality of care issues from the Bahamas reputation perspective – Bahamas is a less regulated environment so there is need to be looking at fully accredited programmes and

affiliated to reputable agencies (universities, hospitals, programmes) even if experimental or pilot

- Protecting the health needs of the communities and managing the health risks to Bahamians – if there is increased risk from communicable diseases, decreased access to needed health care, access to low quality health care, impact on health care costs in the Bahamas for Bahamians – will there be an effect on health status and capacity to monitor this
- Movement of consumers – Bahamas has tradition and mechanism for enabling entry and long term stays through the home owners card, possible that this could be extended to enable retirement communities product – however, the current programme of 2nd home ownership is low density housing and relatively high income groups whereas retirement communities implies higher density models and broader resident profiles and this needs to be thought through. It is known that 2nd home owners migrate back to US when approaching retirement age as they are concerned about access to health care on smaller islands. Where there are retired persons living in the islands, there have been clear benefits to the local community in their contribution of time and money to improvement of local conditions
- Movement of natural persons – need to look at process to manage ‘importation’ of labour for these offshore medical centres – one economic objective is to create employment but not to distort local market – ability to manage movement of clinical professionals will be an issue - although there are clear benefits for liberalizing movement of persons into US for training, updating and building networks. Advantage for Bahamas is many doctors trained in States or UWI which is accredited by UK.

Overall, it is felt that health tourism would be a positive economic development for Bahamas – investment is open even if not structured as it is in the tourism sector. There are many lessons to be gained from other privatisation and

liberalization initiatives. The issues of accreditation and development of the regulatory framework are critical elements for moving forward.

Bahamas Investment Authority

BIA was established in 1993 as the investor's 'one stop shop' in order to facilitate international investors who are seeking to do business in the Bahamas. The BIA reports to the National Economic Council (NEC) headed by the Prime Minister.

The National Investment Policy guides the development of the investment environment which, as it relates to health, ensures that the Government will provide modern health and education facilities and other social services. There have been a few proposals for medical centres as Offshore Medical Centres are identified as an area especially targeted for overseas investors, but only 1 has gone to implementation. Criteria for application is that project must be greater than US\$250,000 and not be intended to serve local population (so as to safeguard the interest of Bahamian providers). No special incentives are provided for health projects. The BIA depends on the MoH for technical input on the proposal but there have been problems with long turn around time and a sense that either the MoH does not have the available capacity to adequately evaluate these ventures or is not been very open to the opportunity of health tourism.

The BIA feels that there is significant potential here as a way to diversify the tourism product e.g rehabilitation services, and believes that Bahamas has the right instruments and capacity to attract the necessary investment.

Private Sector Views

British American Insurance Company

Health Insurance a relatively active part of the business. Markets 3 main health insurance products varying in extent of coverage and range of services and choice. The HMO product is the least expensive and the patient must have a

referral from a local doctor before going overseas. Limiting coverage overseas is the main issue with clients. Quality of care is biggest concern with respect to individual doctors, the range of services provided, PMH and Doctor's Hospital. About 50% of activity is overseas care, and although major effort to control access, for some types of care Miami is less expensive than Doctor's hospital. In addition, clients perceive quality of care better in Miami, want privacy and lump it in with shopping trip. Have tried giving incentives for using PMH, but no significant effect seen on level of reimbursements.

Big issue for clients is portability of insurance across employers. This is where National Health Insurance would be a good thing but concerned about the level of government involvement and the issue of solidarity would be an issue. Private sector influencers in Bahamas would include insurance and chamber of commerce because of their wider understanding of the local business market.

Doctor's Hospital

Doctor's Hospital has 72 beds and offers a full range of general services and specialist services including cardiovascular surgery and a diagnostic centre with the only CT scanner in the country. About 15-18% of activity is generated from tourists, mostly due to need for local services while on holiday. The facility serves mostly Bahamians with private health insurance which is estimated at about 40% of population or 120,000 base. Tourists are usually covered by travellers' insurance and are charged the same price as locals. Doctor's Hospital considers themselves price and quality competitive.

The facility has been working on getting international accreditation for the last 2 years and expects to be accredited within the next year by the Joint Commission for accreditation of International Health Facilities (www.jcrinc.com).

The group also runs a diagnostic centre in Freeport and will soon open a ambulatory centre in the west end of New Providence which has been developed to focus on wellness and rehabilitation for primarily a tourism market. It is also providing a health insurance product with US based Physician network which has

over 4000 doctors registered. There are 4 products, 2 managed care and 2 indemnity type.

Recruitment of qualified physicians is not overly problematic. Medical Council has list of open specialties for which work permits can be applied. Process can be long so for cardiovascular surgery – identify team of consultants then provide credentials, references from recognized countries. The consultants come on a visiting basis as needed/scheduled.

They have not gone into any joint ventures to date, although they have been approached. Advantage of the Bahamas for health sector investors are: tax haven and that they can control market entry because of the less stringent regulatory framework including approval processes for new procedures and drugs. Although, the facility does not pay corporate taxes, there are significant taxes levied: business licence (% of gross revenue), import duties (42%) and property taxes. There are no tax concessions for private health facilities.

List of persons seen

Monday 29 January

Arrive Nassau 8:30am

Mrs Audrey De Veau	Department Health Promotion,
Mrs Fountain	Planning Division, MoH
Mrs Garraway	MoH, PS
Mr Terrence Fountain	Health Information Unit
Dr Patrick Whitfield	Medical Staff Coordinator Princess Margaret Hospital

Tuesday 30 January

Ms Vernice J Walkine	Ministry of Tourism
Mr Herbert Newbold	British American
Mr Phillip Miller	Deputy Director Bahamas Investment Authority
Dr Nelson Clarke	Psychiatrist

Wednesday 31 January

Mr Barry Rassin	CEO, Doctors' Hospital
Mrs Missouri Sherman-Peters	PS, Ministry of Foreign Affairs
Mr Sam Moss	Asst Director Immigration
Mr Freddy Tucker	International Relations
Mrs Roberts	Technical Assistance Division
Mr Curry	Economic Affairs
Mr Turner	Undersecretary, MoH
Ms Mary Johnson	Director of Nursing
Dr Duane Sands	Bahamas Medical Association
Dr Richard Van West Charles	PAHO Bahamas, Country Representative

Thursday 1 Feb

Depart Nassau 7:30 am

Jamaica Country Visit

Public Sector Views

Ministry of Health, Jamaica

The MoH has embarked on a HSRP that involves the establishment of 4 Regional Health Authorities to which public sector employees have been seconded and the process of transferring the facilities to the ownership of the RHAs is now being undertaken. The regionalisation initiative is under the direction of the Division of Policy and Planning that is headed by Dr Margery Cobham.

Health tourism activity falls within the Division of Health Promotion and Protection which is headed by Dr Diana Ashley. The entry point and focus has been on healthy tourism – development and standardization of public health guidelines for the hotel industry (in collaboration with the CAREC project). There has also been a start at developing guidelines for monitoring complementary healing practices.

Workshop on Health Tourism

Funds were made available for an activity on Health Tourism and the MoH commissioned an external consultant active in the area of improving public health standards in the Hotel Industry to develop a project proposal for such a workshop. The workshop was co-funded primarily by the European Commission and PAHO and implemented under the auspices of the School of Graduate Studies, UWI and the MoH.

- To review the present status of Health Tourism in Jamaica

- Propose a path for future development of the Health Tourism Product as part of the enhancement and diversification of the overall tourism product.

The participants included national and regional agencies involved with development and tourism, private health sector providers, investors and the Ministries of Health and Tourism. Key presentations were commissioned by the workshop on the health tourism industry in Jamaica (based on reports done for PIOJ) and international input was sought from PAHO, CTO and Cuba.

The main findings of the workshop was that there were increasing levels of interest about the potential for the industry in Jamaica and an increasing number of products and providers active in the marketplace. Main product areas include: Lifestyle vacations, Spas with high potential for Senior Citizens and retired persons market, behavior modification, reconstructive surgery, aquatherapy, telemedicine, medical schools and products for accompanying family. For the industry to grow and thrive, there was need for more organised activity on the part of Government and its agencies (policy, regulatory and investment) to stimulate and support private sector interest and activity. The health and equity issues were also important particularly in the Jamaican economic context.

The main implementation mechanism was the establishment, under the aegis of the Joint Task Force on Health and Tourism, of a subcommittee on Health Tourism under the leadership of the Ministry of Tourism (which at the time of the workshop was located in the Office of the Prime Minister). Membership of the committee comprised:

- Government: Ministry of Tourism, Planning Institute of Jamaica (PIOJ), JAMPRO (Investment Agency), TPDCO (Tourism Product Development Company Ltd), Jamaica Tourist Board (JTB), Bureau of Standards
- Commercial Private Sector: local investment companies, health insurance
- Selected Private health providers active in the health tourism market

- Regional and international agencies: Caribbean Tourism Organisation (CTO), UWI, PAHO Washington and Jamaica, SERVIMED Cuba

The ToRs of the subcommittee covered:

- Develop policy framework for Health Tourism
- Develop standards and guidelines in line with international standards
- Develop the required regulatory framework
- Collect/review data to determine the inventory of possible marketable services and skills
- Conduct project feasibility studies
- Examine and improve support services and linkages
- Establish a framework policy for malpractice and other insurance, where necessary
- Propose and promote models of private and public alliances that could lead to the establishment of diverse health tourism products
- Develop investment portfolio, with appropriate incentives, to attract overseas investors, particularly those with established brands and to otherwise devise strategies to access equity capital
- Evaluate human resource requirements. Develop and implement HRD policy and strategy to meet required needs
- Monitor and assess impact of model projects
- Assess market trends to determine future directions
- Develop and implement marketing strategies to promote health tourism

JAMPRO

JAMPRO is a statutory agency whose mandate is to stimulate investment in Jamaica. It is organised along industries for which there is a defined investment

strategy and therefore marketing and incentive programmes. It does not have a specific health desk, but is involved in the Tourism sector and is managing any inquiries in health tourism through this department with technical advice from the Ministry of Health. Areas of interest from foreign investors include retirement communities and cancer treatment.

Workshop

JAMPRO was named as a core member of the Subcommittee on Health Tourism but to date has not considered in any detail if there was need for any specific preparation for this role. They would like to see more private sector involvement and leadership and feel that they are well suited to play a key role in the stimulation of investment in this industry.

Trade Issues

Challenge is to develop strategy for trade in health services which traditionally is viewed as social service and therefore has not attracted private sector attention as other industries. Well placed to look at investment incentives bearing in mind that JAMPRO has skills in Tourism, marketing, investment promotion but aware that does not really have inhouse skills or knowledge about health. Lessons to be learnt from Tourism Industry re economic analysis needed to look at benefits of industry of different types of products, the life cycle of the product, and how the economic benefits can be better distributed throughout society. Current work on sustainable tourism could have significance for development of health tourism strategy.

Ministry of Tourism

Interested in moving the idea of health tourism forward but Ministry had undergone several changes since workshop and this has not been a major priority

area. Feels that product group with most promise is the spa offering and that there is a need to look at the divestment of the Milk River and Bath St Thomas spas. Each has their own Board which is community based and charged with development and promotion, but there have been issues with the development programme. Standards fall within the TPDCo portfolio and not with Ministry of Tourism.

Workshop on Health Tourism

The workshop was a good start to look at the issues but was waiting to hear about follow up. Has not actively looked at any of the actions agreed at the workshop but recognizes that the need is growing.

Trade Issues

Marketing and monitoring of standards are two big issues with regard to moving the health tourism industry forward.

Planning Institute of Jamaica

Statutory Agency responsible to the Ministry of Finance and Cabinet for economic and social policy advice and coordinating economic cooperation activity. It works collaboratively with line Ministries in the analysis and development of policy to ensure consistency with national development objectives. Comprises of 4 Divisions and original involvement with health tourism was the commissioning of a 1992 Study on Trade in Services which included health services by Audrey Hinchcliffe and Stanley Lalta. PIOJ had not actively pursued implementation of recommendations of the report.

Workshop on Health Tourism

2 Divisions: Social and Manpower Planning and International Trade and Negotiation participated in the workshop, with PIOJ named as part of core

membership of Sub-committee on Health Tourism, although not involved in followup action. Sees workshop as a good approach and sees that the main benefit as the means to stimulate the development of health services.

Trade Implications

Movement of consumers – need for a proper regulatory framework including legal, policy, consumer protection and financing arrangements to really market a health tourism product – individual providers doing it e.g. fertility centre at UWI. Product development limited by private sector reluctance to invest particularly in economic decline 94-97, may require government to lead i.e. put up investment funds and then divest e.g. Milk River

Commercial Presence – should look at the incentives for investment in the health sector as it relates to health tourism

Ministry of Foreign Affairs and Foreign Trade

Intraregional trade in services has been the main focus and very little work has been done to look at trade in health services specifically. Aware that there are some interest in the private sector on moving forward on this, particularly in provision on niche medical services like cosmetic surgery.

Workshop on Health Tourism

Was not involved with discussions but sees it as positive step forward. Would like to see greater private sector involvement and leadership in the process.

Trade Implications

Movement of professionals – priority area for liberalization – greatest benefit would be the ability of Caribbean nationals to move freely into developed markets

to upgrade and maintain skills. Mutual recognition of credentials may be an issue but the long term benefits in terms of quality of professional skills outweigh short term competitive advantage that foreign practitioners may have. Intra-regional liberalization would be a major step forward, may not want to move to total liberalisation in the first instance.

Movement of consumers – Jamaica's strengths in attracting tourists need can be used to attract visitors to buy health services here. Diversification of tourism product would be main advantage. Building a market of/for returning Jamaicans at retirement age has real potential – remittances form 2nd biggest contributor to national earnings

Commercial Presence – would like to explore the potential of Jamaican networks in US, Canada and UK as potential investors (and also could look at UWI Mona graduates to build referral network)

PAHO

PAHO major concern about health tourism is the ethical and legal context in which the industry will develop and operate. Aware that PAHO Washington is leading some work in this area and that there is documentation on countries which are moving ahead e.g. Cuba, Costa Rica, Mexico and Bermuda.

PAHO Jamaica is active through its participation in the CAREC Caribbean project in promotion of healthy tourism through improving standards of food safety and environmental health in the hotel industry. Dr Pena is also interested in looking at ways to promote 'Healthy Hotels and settings for tourists' as a way to promote healthy living.

Workshop on Health Tourism

PAHO attended and supports the move to a more holistic way of developing the range of products. Have not been very active with the MoH as this is not been an area of activity identified with the MoH for support in the current Biannual

Programme Budget, however very open to becoming involved in a more structured way.

Private Sector Views

Blue Cross of Jamaica

This is a major player in the Jamaican Health Market with about 75% of the market share of health insurance subscribers (40,000), and an estimated 95% of providers registered in the Blue Cross Network.

They are active in market research in health tourism and are supporting the development of products for tourists e.g.

- Development of a traveller's insurance package to be purchased with ticket to cover cost of services while in Jamaica
- International subscribers of Blue Cross/ Blue Shield are covered in Jamaica for use of local health services (clinical gatekeeper function is in place for national subscribers going overseas)
- The development of a wellness tourism product as an extension of their wellness programme
- Promotion of activities in complementary healing and use of traditional or herbal medicines and marketing of such to visitors

Health Tourism activity in Jamaica

Sees that there is an increasing level of activity in health services to tourists – particularly as it applies to wellness products and use of herbal medicines e.g. Vendryes. Treatment products could include cosmetic surgery, increasing use of local services by tourists. Regulation of providers, both clinical and complementary healers, is an important issue and Blue Cross is actively supporting development of a regulatory framework for this practice.

Workshop on Health Tourism

Blue Cross actively participated in the Workshop on Health Tourism November 1999 and views it as an important step in bringing the varied and many players together. However, this macro level activity needs to be supported by practical support to providers who are already active as they cannot wait for all the 'right' elements to be in place. Follow up actions could include:

- A project in the private sector and led by the private sector (or JAMPRO) to improve incrementally the activities they are doing now
- More active private sector participation in the Task Force and Subcommittee
- A regular forum (like the workshop) convened every two years to exchange views and update stakeholders on international and national developments in health tourism

Implications for Trade

Trade issues that they would consider important to the development of health tourism include:

- Movement of consumers – development of key products and marketing; emphasis on wellness products and rehabilitative/recuperative/retirement markets; medical insurance portability
- Movement of professionals – important to liberalise but need to keep a track of quality of practitioners
- Commercial Presence – would need to look at how national interests are protected

Jamaica Hotel and Tourism Association – Community Tourism Secretariat

Community Tourism as a product is being marketed by the JHTA in response to a growing demand and interest in the tourism marketplace for healthful vacations. The Community Tourism concept encompasses a healthy lifestyle concept and covers: herbal treatments/medicine, organic farming and foods and healthy

environments and lifestyle experiences. Astra Country Inn, Mandeville is the principal leader in this development and the owner has developed linkages to other wellness and health services providers like the Menopause Centre, a Dermatology Centre, other natural healers and the Mandeville Hospital. This is further linked to the International Institute for Peace through Tourism which promotes healthy living and vacationing. She has also established the Sustainable Communities for Tourism Foundation which brings together players active in health tourism, ecotourism, culture and heritage tourism and the community at large.

The essential philosophy is built on the need to build a strong relationship between the community and the tourism industry and so ensure that tourism does not have a negative effect on the local people and future generations. This encompasses training of the community on the benefits of a holistic way of life and different ways of making the body healthier on the premise that in turn their attitude to life contributes positively to the feeling of wellness being sought by the visitor. Practical skills are also introduced to encourage them to become entrepreneurs and pioneers in tourism activity in their area.

The Community Institute has also initiated an interface between the visitor and the local health facility – turning the health facility into a local attraction and a direct relationship between the tourism and health services. The health facility is being encouraged to develop business plans and to provide promotional material about the facility and its role in the community so that visitors can see how they can play a role in making the facility's services better for the local community. For example, Astra recently gave free accommodation for 2 weeks to a team of visiting doctors from North America who in turn gave free care to the local community.

Workshop on Health Tourism

Good step to bringing people together but would like:

- To see/know about outcome in terms of the workshop report or follow up steps
- Stronger involvement and leadership by private sector - JHTA well placed to lead an initiative on Health Tourism since it has local chapters
- More open communication and consultation by Government on issues affecting health tourism development during not after formulation of policies that affect tourism sector e.g. new public health regulations for hotels

Trade Implications

- Movement of consumers – development of spas should be prioritised - 15 spa sites in Jamaica e.g. Milk River is not being appropriately developed, should be divested to community not to private sector. Also important for sustainability that product is appropriately regulated and standards maintained – addressing this by inspecting and endorsing only those entities up to standard for and behalf of a network of NGOs

Trevor Hamilton and Associates – Management Consultants

Involved in studies on trade in services generally and health tourism since early 1990s. Sees growing numbers of hotels interested in and doing health tourism in terms of lifestyle vacations. Biggest potential growth area would be the wellness products and retirement villages. A big issue is how to stimulate investment in the supporting health infrastructure and marketing framework. Should look at Cuba experience in developing its health tourism industry. Areas of activity: development of insurance products for tourists (supporting Blue Cross); wellness product development; retirement villages primarily aimed at returning Jamaicans.

Workshop on Health Tourism

Good effort in bringing players together but not involved in any follow up action. Would like to see more involvement of and leadership by private sector.

Trade Implications

Movement of professionals – restrictive practices in terms of movement of doctors into Jamaica to provide services in the private sector

Movement of consumers – portability of medical insurance; development of national standards in keeping with international standards and to ensure high quality of product

Dr Shaun Wynter – University Hospital, Mona, Consultant Obstetrics and Gynaecology

Steady improvements in the range of services at University Hospital. New diagnostic centre for Gynaecology including In Vitro Fertilisation (IVF) was funded through Family Planning Unit introduces the ability of staff to develop and keep new skills. UH has become more business oriented and departments are expected to define performance targets. The IVF service is serving both locals and foreigners and possibly attracting back patients who would have sought service overseas. The Thwaites Private Wing is also thought to be doing reasonably well.

Workshop on Health Tourism

The UH is fairly autonomous and is not currently involved in the discussions on health tourism. The potential of developing a medical tourism product is high with the Thwaites Wing, IVF and the medical school.

Trade Implications

- Cross border trade – talking about telemedicine but constraint is cost of setting up this side
- Movement of consumers – need for marketing support

- Movement of professionals – mutual recognition of credentials would allow easier access for upgrading and maintaining specialist skill but it would still be the issue of getting the right attachment at the right centre

Dr Osmond Tomlinson, Ocho Rios Physician

Predominantly local practice with less than 5% of clients non local. Mostly cruise ship tourists seeking care for minor injuries, although growing number of repeat visits from ship crew who realize that there is reasonable care available (better than on board) and at lower prices. Does not have a differential fee rate, although knows that this is not a common practice for doctors who attach themselves to the local hotels.

Was not aware of any health tourism strategy or of any special incentives for investment in the health sector. Most of the tourists in the Ocho Rios area are young (20-35 year age group), healthy and not noticeably high income range. Finds it difficult to see what products you would develop (apart from spa offerings in the hotels) that would be of interest to them. Villa Viento is a dialysis unit offering dialysis and rehabilitation facilities to tourists (dialysis unit was closed during this visit as they were waiting for a replacement for the dialysis nurse).

Have not personally been approached by Foreign investors, but receive a fair number of questionnaires in the mail requesting information about his practice and asking if he would like to be part of a provider network for insurance purposes.

Trade Issues

Would not like to see health tourism detract from health services for the local community. The potential for medical services is limited as many of the specialists are in fact visiting specialists from Kingston and the only inpatient

facility is in St Anns (about 20-30 minutes by car) which is a public facility which has been recently upgraded.

List of meetings

Monday 29 January		
Arrive Jamaica 12 noon		
Mr Paul Smith	JAMPRO, Director Tourism Development	929 2866(v) 960 8082(f) psmith@jamprocorp.com
Tuesday 30 January		
Dr Trevor Hamilton	Trevor Hamilton and Associates, Management Consultant	
Ms Beverly Reynolds Ms Simone Lawrence	PIOJ, Policy and Planning	
Dr Manuel Pena	PAHO, Executive Director	penamanu@jam.paho.org
Dr Margery Cobham	MoH, Director Policy and Planning	967 1101
Sir Alistair McIntyre	RNM Jamaica, Advisor	754 7989
Wednesday 31 January		
Stanley Lalta	Sir Arthur Lewis Institute, UWI, Lecturer	927 1020
Mrs Angela Taylor-Spence Mr James Stewart	PIOJ, Manager Sectoral Planning and Policy PIOJ, Trade Division	906 4463(v) 906 5011(f) doccen@mail.colis.com
Ms Gail Mathurin	Ministry of Foreign Affairs and Foreign Trade, Director of Trade	926 4220
Ms Jennifer Griffith	Ministry of Tourism, Tourism Planning	920 4924
Thursday 1 Feb		
Dr David Ashley	TRADIJAM, Consultant	

Dr Shaun Wynter	University Hospital, Specialist Physician	935 9326 (pager)
Mrs Dianne McIntyre-Pike	Proprietor, Astra Country Inn Mandeville Representative Jamaica Hotel and Tourism Association	962 3725/7758 countrystyle@cwjamaica.com
Friday 2 Feb		
Dr Henry Lowe Mr Oral Shaw	Blue Cross of Jamaica, CEO Blue Cross of Jamaica, Planning and Projects	927 9821(v) 927 9817(f) henry.lowe@bluecross.com.jm marcoral@hotmail.com
Mrs Audrey HinchCliffe	Consultant	920 4721(v)
Mr Desmond Henry	Private Sector	924 1751
Dr Deanna Ashley	Director Health Promotion and Protection, MoH	967 3750 924 2781 (h)
Saturday 3 Feb		
Dr Osmond Tomlinson	Physician, Ocho Rios	974 2610 oatomlin@cwjamaica.com
Sunday 4 Feb	Depart Kingston	

Dominica Country Visit

Public Sector Stakeholders

Ministry of Trade

The Ministry has not embarked on any specific investigations and planning with Ministry of Health or National Development Corporation with respect to health services or health tourism. However, they can see how trading in health services will be impacted by the commitments for liberalizing under general services trading, and would like to see some clarification on what is meant or covered under 'health tourism' as a service.

Ministry of Tourism

For over 10 years, the potential of tourism for the development of Dominica has been recognized, particularly with the collapse of the banana trade and the need to diversify the economic base. No formal tourism development strategy is in place but the marketing strategy for Dominica runs under the ambit of 'Nature Island of the Caribbean'. The focus, even before it became fashionable, has been on conservation and to maximise the natural assets of Dominica in terms of its rainforests, mountains, healthful environment as evidenced by oldest living person (126 years) lives in Dominica. Dominica seems well placed now to find its niche in ecotourism and health tourism can be developed upon this platform.

Areas of growth and expansion include:

- Cruise ship tourism – 3 berths in Dominica and significant growth in last 5 years reaching about 270,000 'visits'/year.
- Stayover visitors
 - focus on hiking, water sports including diving (Dominica rated as having 1 of Caribbean's top 5 diving sites), whale watching

- currently has 750 beds mostly small hotels, locally owned with a couple bigger hotels
- plan to increase capacity to 1250-1300 beds and would like to attract a flagship hotel (brand name), topclass perhaps 300-400 beds which will have the following benefits
 - help marketing of Dominica through the hotel's marketing network
 - raise the standard of services, facilities and management in Dominica through employment and knowledge transfer
 - seen as complementary to small hotel capacity rather than alternative
- promotion and marketing programme needs to be strengthened but not cost justified until the bed capacity reaches 1250-1300
- looking at a process of controlled development

The following are acknowledged barriers to growth and efficiency:

- airport infrastructure:
 - lack of facilities for night landings
 - no direct access from target markets – Dominica accessed through San Juan, Antigua, St Lucia
- road infrastructure
 - poor condition of existing road network
 - difficult and costly to develop new roads
 - access to many of the potential tourism sites difficult
 - Roseau not very conducive to pedestrian cruise ship tourists
- Development of Tourism sites
 - 50 sites have been selected for further development so as to ensure that no one site is overloaded beyond a normative carrying capacity
 - only 5 sites have been funded so far
- Financing of promotion and marketing programme

- Name recognition is an issue – often confused with Dominican Republic
- Product promotion
 - Strategy for multi-island destination product
 - Adjunct to typical sun, sea and sand tourism product
 - Aimed at travel agents in target markets, tourism authorities in neighbouring islands, airlines, CTO
- Human Resources Development/Training
 - NDC is frontline responsible for programmes for providers
 - Scholarships for hospitality industry
 - Community Training college – development of hospitality programme
 - In house training for MoTourism in terms of policy and programmes
 - General public
 - Schools through MoEducation integrated into school curriculum 2001-2002
 - Communities – Tourism committees “tourism is everybody’s business”

Potential for health tourism

- Wellness products
 - Managed by tourism sector
 - Linked to eco tourism development
 - Spas, natural products, complementary healing
 - Recuperating from surgery
 - Possibility for Layou Valley Resort to develop as such a centre linking organic farming, self sustainability
- Treatment products
 - Cosmetic surgery

- Biggest strengths are privacy for client and warm, tropical environment for recuperation (recuperation would be linked to the tourism facilities)
 - Possibility of sharing services with other OECS countries e.g. pathology services, specific specialties based on resident skills
 - Hyperbaric chamber – currently send patients to Martinique, but essential if going to grow diving business – ‘one fatality can cost the industry’
 - Benefits to Dominica include
 - Improve range of services available (and affordable) to people by increasing volume and quality
 - Manage unit costs
 - Needs more planning and attention to detail
 - Health will play a role here
- Rehabilitative services
 - Capitalize on tourism infrastructure (linked to health services)

Ministry of Health

Primary focus is on health care for local citizens and public health. In Dominica, the Ross Medical School falls under the MoH in terms of regulation and monitoring which is considered as ‘medi-tourism’ and an important contributor to the local Portsmouth economy. Dominica Medical Board is now considering a request from Ross to accredit the graduates of the school, as they need to be accredited to facilitate the students’ entry into continuing programmes in the USA.

Supporting activities listed by the MoH to Health Tourism would be the CAREC project on Healthy Tourism, Public Health Surveillance, regulation of standards of providers and hospitals.

The MoH feels that there is serious potential for complementary medicine activity in Dominica and for Health Tourism but currently does not have either any regulatory activity or a joint planning forum with the traditional healers or those dispensing traditional medicines. There is also no joint planning with the Ministry of Tourism either to monitor the quality of health products to the tourist market or to evaluate the impact on local services the growth of the eco tourism or nature tourism industry.

Princess Elizabeth Hospital

The Hospital provides services to tourists in 2 ways: minor injuries and ailments and treatment of cruise ship tourists that cannot be handled on board ship. The hospital levies charges for these services, which are higher than for residents, and have had no problems in collecting fees. For Cruise ship tourists, the local agent plays a key role if the patient does not have insurance.

The Hyper baric Chamber is to be located at the Hospital but clinicians are still to be trained to manage the programme, and no discussions have been held to plan implications for recurrent expenditure and how this serviced will be financed. Currently, patients are transferred to Martinique for care and the numbers are extremely variable – from none to 2 or 3 a year.

The facility comprises 224 beds including 55 psychiatric beds. Occupancy rates average 70-75%, with Medicine/surgery over 90% but with very high average length of stay due to presence of chronic patients on the ward and paediatrics around 35%. Thirty doctors are employed by the hospital, 14 of them are specialist level and they are allowed private practice. There are 3 nursing categories giving a total complement of 300 nursing staff with about 50:30:20 split registered nurse to nursing assistant to aides. There are no private beds although this was tried in 1980s.

The hospital charges patients on a fee for service basis, the tariff level differs by resident, non resident and non national. There are problems with collections,

particularly for surgery. Those exempted from these fees include children under 15 years and welfare recipients (covering about 50% of the population).

Much of the hospital development has been done with technical cooperation programmes with France supported through Guadeloupe and Martinique. There has been discussions about further expansion of the hospital but none have involved planning for health tourism or expanding needs of services by or for tourists. Most of the referrals are now sent to Guadeloupe or Martinique depending on the nature of the complaint.

National Development Corporation (NDC)

NDC is a State Corporation set up by Act of Parliament in 1983 to promote and support investment in Dominica. It is accountable to the Ministry of Trade and Industry and covers 4 main sectors: Tourism, agrobusiness, information and services, managed by two main directorates – Tourism and Industry. In order to achieve its mandate, NDC is responsible for marketing of Dominica and the products/services and attracting proposals for investment. It works with the line Ministries in the implementation of strategies, but the Ministry is responsible for the development of the strategy and regulating the industry.

Within these two portfolios however, there are issues about the development of the industry itself and whether NDC has the capacity or the mandate to do that. Whereas it is felt by many tourism providers that Dominica's problems are related to marketing, NDC feels that there is still a lot to be done in terms of improving the quality of the product both by the public and private sectors and that NDC's role is to provide support to do that.

With respect to health tourism, NDC has seen proposals about developing spas in keeping with the 'Nature Island of the Caribbean' thrust. It, however, will depend on MoH to evaluate health related projects. It is not involved with the development of medi-tourism i.e. the Ross Medical School. There has been no joint planning with MoH re quality and capacity of local health services to

support the implementation of the Tourism strategy to a more active, nature style product.

Private Sector Stakeholders

Ross University Medical School

Ross University campus is located in Portsmouth, with its administrative headquarters in New York. It is an offshore American Medical School, where the students spend 4 preclinical semesters in Dominica with the 5th and final preclinical semester at the University of Florida (this is a change within the last year which is viewed as positive for the school as it facilitates entry into clinical programmes and further validates the quality of the programme on Dominica).

Ross University has been in Dominica for about 22 years, starting with a few students growing to a current enrollment of approximately 780. They take in new students twice a year, with a view to increasing the intake to 3 times/year to balance the loss of the resident population due to the movement of the 5th semester back to the States. Admissions is managed through the New York office as well as financial management issues including payment of the faculty. Most of the faculty is international, and the current Dean is Dominican. Dominican clinical practitioners teach on a sessional basis.

The University has recently changed owners and it is generally expected that they will introduce changes in the school to stimulate further growth and expansion although it was unclear during this visit which direction this would take.

The University pays taxes but is duty exempt. The indirect economic benefits include:

- the international exposure of having a medical school in Dominica,
- the potential for attracting highly skilled Dominicans back home by providing another avenue to use skills,
- stimulating the development of infrastructure to serve the relatively wealthy student and faculty population

- increasing personal incomes particularly of the people of Portsmouth through rentals, food, recreational spending of students and their families
- employment of local staff: part time clinical faculty, administrative, maintenance.

Papillotte Hotel

Papillotte is one of the first hotels to begin to offer a product based on the nature aspects of Dominica. It was started back in the 60s and has grown into a 7 unit hotel for nature lovers. 90% of its business is internet generated and personal references. The clients are mostly professional (a fair number are doctors and information systems) and originate in the US, Europe (mostly UK) and other::60:30:10. The website is managed through the US, by someone who came to stay at Papillotte about 8 years ago and offered to set it up for the owners and has managed it since the inception.

They have tried networking with other Caribbean nature sites, but it relatively informal and has not progressed really. The potential and interest in nature tourism is great but constraining factors include:

- maintaining the quality and interest of the local staff in providing good service and maintaining standards
- balancing the developing of this niche with the cruise ship market – completely different customers and demands on the local communities
- the volume of cruise ship persons difficult to manage in the way that they would like e.g. they would get 50 people for a garden tour – it is very difficult to provide a quality interaction for this size group
- the nature of the cruise ship business (the hustling at the port and the role of the cruise ship operators) makes it difficult to motivate staff and to keep young people interested in a slower pace at the hotel
- changing the feeling of Dominica, not sure it is compatible with the Nature Island thrust

- marketing issues – most people do not understand the market they are trying to serve – glossy advertising and mass marketing is not how to attract this market.

Over the years, there is a growing interest in complementary healing and many more people involved in providing services e.g. since the small influx of Taiwanese through the economic citizenship programme, there are practitioners in acupuncture and other Eastern healing practices.

Eco Inns

This is a group of 9 small hotels/inns/facilities (one is a garden) focusing on eco tourism and nature tourism products. They are part of the overall Hotel and Tourism Association, but felt that they needed to form their own grouping as they have different needs (marketing) and issues to the larger hotels – the largest in the group has 16 rooms, but most on average have 5-8 rooms. Papiotte is a member of this network.

They are marketed as a group and the client chooses depending on their particular preference. Each inn still has the ability to market independently, and manages its own bookings. Some clients will stay at more than one Eco Inn during their visit, and the Eco Inns facilitate the client in moving from one location to another.

Eco Inns sees that the development of health tourism as a key development for them as they offer a healthy package to the tourist, and would benefit from the marketing of Dominica as a health tourism destination.

OECS/EDADU (Export Development and Agricultural Diversification Unit)

This unit is set up with a mandate to support the development of private sector capacity for products and services for export. It provides support for business planning, marketing and product/service design and for the development of

strategies and approaches for economic diversification. EDADU is now involved with promoting trade in services in general, and is looking at the film and entertainment industry in more detail.

List of persons seen

Sunday 14 January

Arrive Roseau

Mrs Anne Papillote Hotel

Monday 15 January

Hon Osborne Riviere Minister of Trade, Industry and Marketing

Mr. Allan Paul Director of Trade

Hon Charles Savarin Minister of Tourism

Mrs Toussaint Hospital Administrator, Princess Margaret Hosp

Mr. John Fabien PS Min. of Health

Dr. Colmore Christian PS Min of Tourism

Dr .Etienne Chief Medical Officer

Mr Sobers Esprit Director of Tourism, National Development Corporation (NDC)

Ms Ophelia Marie Deputy Director, Marketing

Ms Sharon Pascall Ag Director Industry Tourism Product Development

Tuesday 16 January

Mr Dudley Chase Export Development Advisor, OECS/EDADU

Mr. McCarthy Marie Eco Inns

Visit to Ross University Ross University, Portsmouth

Dr Pascal Medical Director

Princess Elizabeth Hospital

Wednesday 17 January

Depart Dominica

St Lucia Country Visit

Public Sector Views

Ministry of Health

Primary focus is on health care for local citizens and public health standards. MoH has embarked on a reorganisation programme so as to strengthen the capacity for policy and regulation. Environmental protection issues are considered priority issues and the aim is to bring standards up to international level in both health and tourism infrastructure.

Currently, however, health planning and policy lag behind the 'marketing' of tourism. Efforts to improve this situation involve the National Conservation Authority, the Bureau of Standards and Ministry of Planning. Problem is that every agency is using a different terminology and have different priorities, no one is coordinating and MoH does not play a lead role in the tourism sector even in terms of providing services, they go to the private sector.

MoH has started the planning for a new Victoria Hospital funded by the EU. Previous attempts to redevelop the present site has resulted in a very difficult configuration to integrate services in a user friendly and efficient manner. Access to the present site has remained problematic. The new Victoria Hospital will be approximately 200 beds and is EU has committed about EC\$40m. To date, the planning has not considered health tourism or the use of local health services by tourists as a particular issue, neither will there be provision made for a private wing. As part of the ongoing plan for improvement of services, the MoH has recruited a senior manager to run the hospital and to lead the redevelopment agenda.

MoH is not aware of Tapion Hospital plans for expansion particularly as it applies to health tourism, but thinks that it would be better placed to provide this level of care.

OECS Secretariat

Although there is interest in looking at improving sharing of health services in OECS e.g. the Eastern Caribbean Drug Service, where the OECS have managed to improve purchasing efficiencies for pharmaceuticals, no detailed discussions are ongoing about trade in health services or health tourism. The critical issues that will be needed to support this agenda would be the free movement of professionals and the development of the infrastructure and systems for the countries to compete internationally. Whereas the ECDS is considered a success, it does not interfere with or attempt to rationalize what each country will provide – health tourism will essentially imply a competitive basis and not every country will benefit in the same way. This will be a big issue for implementation in terms of how the OECS Secretariat can help in terms of strategy development.

OECS Trade Policy Project

The OECS Trade Policy Project was developed in response to a request from the Heads of the OECS to CIDA and is being implemented under the project management of the Canadian Executing Agency (the CEA - Deloitte Touche/Tohmatsu Emerging Markets). The duration of the project is approximately 5 years from October 1999 to Dec 2004, with the detailed design phase completed in March 2000. Project activities are being delivered through a mixture of short and long term technical assistance, training and overseas attachments using an iterative process with the CEA working in consultation with the OECS and the member states.

The project purpose is to strengthen the OECS capacity in three areas:

- the development and maintenance of an OECS international trade strategy
- to meet obligations under regional and international trade agreements
- to participate effectively in international trade negotiations

If the project is successful, then it is expected to see increased participation of the OECS in reciprocal rules-based trade agreements and increased trade and investment from greater participation in the global market economy. In the longer term, the capacity of the OECS sub region to participate and compete in the global economy will be improved.

Project outputs include:

8. Sub regional trade policy framework prepared
9. Strengthened capacity of national and sub-regional public and private sector institutions to develop trade policy
10. Priority obligations under trade agreements implemented
11. Strengthened support role for OECS Secretariat in meeting member state obligations
12. OECS strategy for trade negotiation prepared
13. Strengthened trade negotiation support from the OECS Secretariat
14. Staff trained in trade ministries, OECS Secretariat and private sector associations

The project sees that one of the biggest problems in moving the trade agenda forward is the segmentation and dissecting of the issues by country, by sub region, by sector interest (public and private), by industry (health, IT, financial etc). The fact is that 78% of OECS trade is already in services and what is needed is a more holistic approach in looking at how to move forward rather than trying to recapture lost markets and old relationships.

In the first year, the project has focused on sensitising the OECS countries through a series of workshops involving both private sector and trade officials on: the content and implications of GATS, the role of services in the OECS and the value of trade to the economies of the OECS. These initial workshops are being followed up by working sessions looking at particular service areas based on country priorities which they identified themselves where participants are being asked to work on strategies for developing trade in their service area. St Lucia had a working participant from Tapion Hospital in one of these sessions.

Key issues that have been highlighted in the project include:

- Communication among the various players – wide participation is invited in the workshops but information is still being compartmentalised. Clarity is need in terms of who deals with what and how to involve and engage the private sector so that they can begin to take a bigger role in shaping public policy
- Lack of awareness and knowledge on
 - What is available locally and regionally – an inventory of services and resources
 - The issues of development beyond the domestic agenda
 - The legislative context needed to compete internationally
 - The big picture in terms of benefits and pitfallys
- The availability and use of incentives not only for to attract capital but for technical/management services – this requires being able to negotiate on the basis of strategy not short term gain
- Ministries of Foreign Affairs/trade are the coordinating bodies in the countries for trade relations and international negotiation but their effectiveness is constrained by the lack of a high level secretariat for implementation.

If the issue is limited resources, then the way forward must look at how these resources can be optimized outside of the normative boundaries that comprise the politics and culture of the region and subregion.

Private Sector Views

Chamber of Commerce

The capacity of the health services in St Lucia is of concern to the private business sector both in terms of quality and range of services available. Much of this interest was borne out of a need for faster and more private service for the families rather than a concern for their employees. About 5 years ago, a group of

concerned citizens approached a group of doctors and purchased the Tapion Hotel site which has been converted into a small private hospital under the direction of a Executive Board, made up of both doctors and representatives from the business community.

The business owners generally recognise that this venture will not generate large profits, needs a longer time to see a return (which in the end may be more about equity rather than income), speaks of social responsibility but do expect Tapion to cover costs and to provide a good service. The Chair of the Board is a doctor who essentially works as the CEO. The level of satisfaction is reported to be high among the shareholders about the success of the venture, as some level of comfort has been achieved by having access to doctors and a facility as it is required.

It does not seem an option that if the Victoria Hospital is rebuilt that in time the new hospital could provide any real competition to Tapion because the Government will not be able to manage the facility to provide the quality of service that is needed. The private sector does not feel that it has any power to influence if some of that money could be channeled to Tapion or that Tapion could take make a bid to manage the new hospital.

Tapion Hospital

Tapion Hospital is a locally owned private facility located in Castries. It provides a full range of secondary hospital services, and is continuing to expand the range of subspecialties available. The growth has been significant since it was set up in the mid 1990s. It is run by a Board, comprising of the owners i.e. doctors and business people, which for operational purposes maintains an executive approach and role to the running of the hospital.

Specialty services include x-ray, laboratory and dialysis services the latter is a 'joint venture' with an international provider. Tapion is also currently negotiating to enter into a similar arrangement with a French provider for cancer services. The services provider rents space from Tapion and is responsible for the

marketing and promotion, provision of the service and financial management issues. Tapion Hospital effectively acts as a landlord and is responsible for the location and general but not specific maintenance. Services, as ordered by the attending physician, are purchased from the provider. Tapion does not know the details of feasibility study underpinning the cancer treatment service, except that it is meant to be a regional service bringing in patients from nearby islands.

Other opportunities for health tourism include: other sub specialty surgery e.g. cosmetic surgery, pathology services, psychiatric/rehabilitation care, chronic long term care, nursing home, telemedicine services. The demand is there, the private sector needs to create the products and market them – intraregional and then extraregional or internationally.

St Lucia has the competitive advantage in terms of

- proximity to USA,
- available expertise with most doctors having specialized in North America or Europe,
- less expensive,
- access to new technology e.g. telecommunications.

Barriers to progress in this area include:

- Not enough trained personnel (quality is not the problem);
- coverage in medical insurance;
- high cost of capital;
- poorly developed networks and capacity to market;
- lack of supporting infrastructure (e.g. telecommunications expensive for telemedicine);
- lack of regulatory capacity to control over supply situation in the country and to maintain quality standards in the country;
- poorly developed financing mechanisms – not everyone covered by insurance.

List of persons seen

Wednesday 17 January

Arrive Castries

Mrs Charmaine Gardner Caribbean Association of Industry and Commerce

Ms Sophia Bryan Marketing Coordinator, Le Sport

Dr Stephen King Tapion Hospital

Dr Martin Didier

Stewart Smith CEO, Victoria Hospital

Thursday 18 January

John Husbands Deputy PS, Ministry of Health

Darrel Montrope Chief Planner

Wenn Gabriel Ag Chief Environmental Health Officer

David Joseph Asst CEHO

Leo Plummer Senior EHO

Parker Ragnanan EHO Food Unit

Charles Cadet Project Coordinator

OECS Trade Policy Project

Virginia Paul Common Affairs Officer, OECS
(Formerly Ministry of Trade St Lucia)

Depart St Lucia

Trinidad & Tobago Country Visit

Public Sector Views

Ministry of Health

The MoH is not actively involved in specific initiatives on health tourism or trade in health services issues. The focus has been in the implementation of the Health Sector Reform Programme which aims to improve the quality of health services available to the population and using the strategy of the separation of the government's provider function from its 'purchasing' function. The HSRP comprises of 4 key components:

- Establishment of 5 Regional Health Authorities to manage and provide health services to the general population in keeping with national policy
- Reorganisation of the MoH to strengthen its role in policy and regulation
- Modernisation and rationalization of the public provider network to improve efficiency and quality of care in a sustainable manner
- Continued work towards the implementation of a national health insurance system

To date, the RHAs have been established, management teams appointed, physical assets have been transferred but transfer of staff to the employment of the RHAs has been delayed. The latter has had a significant effect on the ability of the RHA to manage the services and there have been a series of HR crises with respect to conditions of service, particularly salary, for both nurses and doctors. Shortages of nurses remains a particular concern and Trinidad and Tobago has become one of the key destinations for nurse recruitment.

From the MoH's perspective, work has been ongoing in the Directorate of Quality Management in the development of a quality framework including new legislation, licensing and accreditation issues and establishing mechanisms for monitoring customer satisfaction. The Health Services Act has been drafted to replace the current Hospitals Act and to establish the framework for monitoring quality in all health facilities, including laboratories, diagnostic centres, outpatient clinics and day surgery centres which have been growing in an unregulated fashion to date. Both RHA and private facilities will be governed by this law. Work is also needed to modernize the Public Health Act and for improving professional self regulation.

The MoH expressed concerns about the effect of health tourism on emphasizing the shift of the labour force away from serving the general public towards more elitist groups (i.e. those able to pay higher prices) and also increasing the demand for more expensive services. There were perhaps opportunities to balance this through the contracting of private services on behalf of the population, but many of these more highly specialized or esoteric surgeries are limited in the public domain by the simple absence of it, and mechanisms for controlling the introduction of technology (and replication of expensive resources in the private sector to the detriment of quality and sustainability) are not yet in place. Work on national health insurance would also be a key instrument in ensuring equity and rebalancing distribution of financial resources for health and the impact of health tourism would need to be included in the modeling.

Ministry of Foreign Affairs

Brief involvement in the early to mid 1990s in trying to set up CARICOM linkages for the sharing of services from Mt Hope. Role including facilitating contact, inclusion of EWMSC in CARICOM events marketing services and products available in Trinidad and Tobago, looking at ways to minimize entry of CARICOM nationals to seek care. Since this early involvement, EWMSC set up a Caribbean Desk themselves and governments now contacting directly. At the

time, keen interest in EWMSC was expressed by Grenada, Guyana, St Kitts and Antigua.

Tourism and Industrial Development Company of Trinidad and Tobago Ltd (TIDCO)

TIDCO has no specific mandate for health sector investment, but is set up to be the entry point for foreign investment inquiries in the country. It can provide general information about the establishment of foreign companies and investment incentives that generally can apply to health. They have not been involved with any projects to date re health tourism or more general trade in health services.

Most of the activity in tourism is focused on Tobago, and there are a range of incentives available and a Tourism Act which formalizes these incentives is pending. TIDCO acts as a facilitator and catalyst for private sector investment in Trinidad and does not have direct relationship with health authorities, or has to date not included health authorities or the MoH in discussion about the effect or potential for business when reviewing tourism developments e.g. Tobago Hilton Hotel. The Tourism Master Plan is based on aspects of sustainable tourism but not exclusively. Eco tourism is one of the main approaches for tourism development in Trinidad.

Tobago RHA

Tobago RHA and the Tobago Health Services, primary care and hospital teams, are not actively involved with activity related to health tourism. The Planning Division of the Tobago House of Assembly is responsible for the development of tourism and the Tobago Master Development Plan does mention health tourism with respect to cosmetic surgery and retirement communities, but no attempt was made to look at the potential impact of introducing these services on the development of the new Tobago hospital. Provision in the design and layout of the hospital will allow a private wing or private use of the facilities but there has

been no consultation with the Hotel Association or individual persons involved with tourism on how this would be encouraged. For example, no discussions about the spa development on Tobago Plantations Ltd have been initiated either by the RHA or THA or TIDCO and the potential for collaboration with the new hospital development.

Eric Williams Medical Sciences Complex

Facility

EWMSC was constructed about 15 years ago with facilities comprising:

- 350 adult beds
- 250 paediatric beds
- 22 operating theatres
- outpatient clinic facilities designed to accommodate private practice
- diagnostic support services
- dental, medical and veterinary schools
- 100 bed women's hospital (opened about 5 years before completion of EWMSC and still managed as independent entity)

There have been significant problems with the commissioning of the complex mostly related to agreement or lack of agreement on the strategy for the staffing of the Complex and funding of the recurrent budget. EWMSC was set up organisationally as an independent statutory authority in order to improve the management of the facility and to give it the ability to function outside the normative constraints of public sector i.e. more freedom to recruit staff, attract patients outside Trinidad and Tobago, raise revenue. However, without a supporting strategy within the public sector, the Complex found it impossible to attract the numbers of staff that it would need and to pay its bills.

With the implementation of the Health Sector Reform Programme, EWMSC became subsumed under the Central RHA with the intention that hospital services would be rationalised among Port of Spain General Hospital, Caura Hospital, St

James Medical Complex and EWMSC – this essentially translated into movement of existing staff and resources into EWMSC. However, this has also not materialized with only partial implementation of the National Health Services Plan and EWMSC still not completely commissioned.

Currently, the following services are provided at EWMSC:

- Paediatric Services including neonatology and paediatric surgery
- Ear, Nose and Throat Services
- Orthopaedic services
- Chest Medicine
- Cardiothoracic surgery (managed by Caribbean Heart Ltd)
- Renal Medicine (including renal dialysis)
- Dental, medial and veterinary schools
- Diagnostic (CT scan, ultrasound and radiological) and lab services

Plans are being discussed for:

- Cancer treatment centre (radiotherapy, chemotherapy)
- Joint replacement service

Marketing and target markets

No active marketing is done for EWMSC services on the international market because of the incomplete commissioning of the hospital. Specific services like the Cardiothoracic are marketed locally but the main source of referral is personal recommendation. Some joint presentations were done with the Ministry of Foreign Affairs when the Complex was first set up, but because of the failure to operationalise many of the services, this was never formalized. Foreign patients use the complex on a fee for service basis, mostly on a Government to Government arrangement – they originate predominately from Guyana, Grenada, Antigua and St Kitts. The Complex has a Caribbean Liaison desk to facilitate entry, accompanying family members' logistics and payment – this has helped significantly to improve patients' satisfaction with the services.

Inter American Development Bank (IADB)

IADB is the major development agency involved in Trinidad and Tobago and is currently financing the GoTT HSRP. Within the programme, the assessment of need and justification for a new hospital for Tobago was based on the need for a modern facility to support tourism development, mostly as it relates to use of local services by tourists rather than there was any plan for health tourism per se.

The IADB would like to see a more structured approach to the utilisation of the private sector in health, but recognizes that there is a development agenda with respect to improving the regulatory capacity and building some organisational capacity for the safeguarding of equity in health. There are no plans independently of the HSRP to finance private sector as the relationship is directly with the Government.

Links have been made between the HSRP and the Community Development Fund (CDF) under the Ministry of Planning for the funding of community based projects for the care of the elderly and children with disabilities. The CDF is administered by the Self Help programme but funds are only to be accessed by NGOs, CBOs or private sector for projects that have a community benefit.

IDB HQ is also funding, jointly with CDB, a project on 'healthy tourism' which is being implemented by CAREC. The aim of the project is to improve standards of public health in the hospitality industry. (see CAREC)

Caribbean Epidemiology Centre (CAREC)

CAREC, in collaboration with CAST (Caribbean Action for Sustainable Tourism), is implementing a project on Healthy Tourism with the overall goal to improve the quality and competitiveness of the tourism industry. The project purpose or end of project impact will be the establishment and dissemination of quality standards, systems, and registrations designed to ensure healthy, safe and environmentally conscious products and services for guests and staff. The

countries involved include: OECS, Bahamas, Barbados, Jamaica and Trinidad and Tobago.

Specific project outputs include:

1. development of health, safety and resource conservation standard-based systems and registrations for the tourism industry
 - a. conduct an ongoing needs assessment for the tourism industry and implement an ill-health monitoring system among participating tourism establishments
 - b. implement and validate a Caribbean wide health, safety and environmental system of standards
 - c. establish and implement an auditing process based on approved standards
 - d. develop training programs for industry trainers, consultants, auditors and public regulators
2. Implementation of marketing, promotion and sustainability strategies
 - a. Develop and implement strategic marketing efforts linked to a recognisable brand identity for the standards-based system and registration process, including the establishment and maintenance of a project website and the production and distribution of publications and bulletins on health, safety and resource conservation
 - b. Develop a long term strategy for broader implementation based on project results and lessons learned from the project

A 'joint venture' agreement between CAST and CAREC has been drawn up and the project will run for 3 years from 1999-2002. A Project execution unit (PEU) has been established in CAREC and is accountable to a Steering Committee comprising public and private sector representatives jointly nominated by CAST and CAREC. The project is being co-funded by the participating countries and the IDB through the Multilateral Investment Fund (MIF), with the intention that the longer term sustainability will be addressed through the collection of fees

from hotels and other establishments for training, audits, inspections and registration.

One of the biggest hurdles in the project startup period was getting the cooperation of the hotels in the process and to build understanding of the longer term benefits to the industry. Many of the smaller hotels felt that this would mean more work and higher costs for them, particularly in the short term and could not see how this would help them to compete. Others felt it was going to be another bureaucratic imposition by the MoH in terms of adhering to standards etc. The larger and more progressive hoteliers who had standards in place welcomed the project and could see the benefit to the industry in the longer term, particularly some form of registration or accreditation which would be recognized by tour operators.

International Labour Organisation (ILO)

The ILO Caribbean Office is working closely with governments, employers and trade unions in the fields of employment creation, human resource development, social security and social dialogue. The ILO has not been involved with specific activity related to health tourism or analysing the labour situation in the health sector. However, it does have background and interest in the tourism sector and is embarking on a study to lay the basis for its involvement in the tourism sector and to formulate guidelines for activities in the next 2 years.

The ILO feels that decent jobs, less combative labour relations and HRD will contribute to productivity and sustainability of the sector. They feel that a regional research programme is required (in synergy with CTO and UWI) which will include regular statistical monitoring, development of models to look at economic gain as well as cultural, social and environmental impacts. The output of this research programme would be used to design and reach social consensus on strategies, policies, programmes and instruments that would allow countries to steer their tourism industry towards sustainable development.

The background study is to be finished around April 2001 and will look at available data on tourism and their location regionally and more in depth six country studies including Bahamas, St Lucia, Barbados, Jamaica, Guyana and Trinidad and Tobago. The output will be used:

- to support the planning of the Joint ILO/CTO tripartite meeting in April 2001 on “Labour in the tourism sector”
- to develop an approach to the tourism sector in the region
- develop cooperation and synergies with other regional and international organisations including CTO, UWI and CDB
- finalise input for the ILO Caribbean Office meeting on the hospitality industry in April 2001

Private Sector Views

International Finance Corporation (IFC) Latin America and Caribbean Division

IFC has set up a small office in Trinidad covering the Caribbean. The IFC is capable of financing relatively large projects in the private sector and has instruments which are generally not available in the commercial banking sector. Although the source of financing is cheaper, the lending rates are compatible with the commercial sector so as to compete fairly. IFC is not currently funding any health sector initiatives, although considering tourism proposals.

The key characteristics of a project that will be considered by IFC include:

- Clear definition of the market
- Technical and managerial capacity to implement the project
- Financial analysis demonstrating the longer term feasibility of the venture

There are no particular incentives or special concessions for the social sector, including health, but IFC considers that the technical support that can be offered through its Washington based team would be invaluable to improving the quality of many of the investment ventures in the Caribbean. Clearly, capital and access

to affordable capital and supporting investment incentives are important in attracting investors interest, but in the Caribbean they are not critical success factors for implementation. Often the viability of the project is undermined by the lack of technical and managerial capacity to run the venture and for large projects, this must be addressed e.g. by including the cost of a management contract with an international firm, joint venturing with international partners on the investment.

Hilton Tobago

Facility

This is the most recently opened resort complex in Tobago with the hotel operating over 200 rooms commissioned in late 2000. The hotel is located in a 750 acre complex managed by Tobago Plantations Ltd (Angostura and Guardian Life). Although there is no formally marketed wellness/spa product, the hotel notes that there are many enquiries for spa type facilities. Currently they offer as amenities in the hotel:

- Health Club – Fitness and massage centres (co-managed with a beauty salon)
- Water sports
- 18 hole Golf Course
- Tennis
- A range of physical activities including walks, cycling, aqua-aerobics, site seeing tours

TPL plans to develop an additional spa facility for use of the villas and hotel within the next 12 to 18 months. Discussions have included possibility of the development of a cosmetic surgery offering (including its own facility) complemented by recovery period in the hotel and supported by the spa product.

Environmental focus

The management is committed to environmental conservation and actively supports a clean beach programme, environmentally friendly systems for golf course maintenance, use of 'gray water' for irrigation and flushing, strict sewage management practices. It is dependent on the public water supply which is well sourced and said to be of excellent drinking water quality.

Use of Local Health Services and emergency care

They do not receive regular enquiries about the status of health services on the island. They have a resident nurse in the hotel (8-5 pm) for first aid and more general nutritional advice, with on call cover from a local GP who manages the medical referral and medical evacuation. Depending on the clinical situation, evacuation can be to Trinidad or Barbados principally. The hotel caters for specific nutritional requests within the normal room charge e.g. diabetic, heart disease etc. – dietary needs are managed by the Chef. It is wheelchair accessible.

Marketing and target markets

Marketing is done principally through the Hilton Network and one of the key approaches is to market a 'Hilton Caribbean' product so as to optimize the attractions of one location and minimize the internal competition in the region. Joint marketing is also done with TIDCO and THA. Target markets are upper income from North America and Europe.

Kariwak Inn

Facility

This is a small 24 room, owner managed hotel started in 1982 with a vision to develop a product which represented 'what the Caribbean was all about' and has evolved particularly over the last 5 years into a facility geared to providing its guests (resident and non resident) complementary health services. Range of services offered include:

- Therapy centre with 2 trained therapists in physical therapy and complementary medicine
- Regular activities included in the room charge covering
 - Tai chi, Qi gong, yoga, stretch and relaxation
- Ayurvedic and shiatsu massage therapy
- Reflexology
- Stress reduction treatments

The development of its health products has been inspired by the owner's own personal beliefs and philosophy about healing and wellness and through learning about international developments in this field, particularly from a Canadian network. The therapists are both European and there has been no problem to date with recruitment or retention.

In their view, their facility is unique to Trinidad and Tobago, and can be complementary to other wellness products on the islands.

Environmental focus

The management is committed to environmental conservation and grows its own vegetables and buys locally to the greatest extent possible.

Use of Local Health Services and emergency care

By nature of its clientele and products, there is no heavy utilisation of the local health services and no formal linkages.

Marketing and target markets

Marketing is done principally through personal recommendations. The hotel does have a website, but does not aggressively market itself internationally. It has consistently run an occupancy rate of 80-90% except for 2000, when the entire island experienced a slowing down of activity. Occupancy for 2000 has averaged around 60%. Visitors are predominantly from Canada and Europe. Local residents make up about 20% of business.

Health Net

Facility

This is a private health provider network owned by the CLICO Group, an insurance company which has diversified into several other sectors including financing, energy, housing development, entertainment. The network comprises 3 primary care centres (Barataria, Trincity, Couva) and 1 comprehensive care facility (Woodbrook) – the latter provides both primary, specialist and inpatient services (20 beds).

At its primary care centres, both dental and medical care are provided using dentists and general practitioners. No qualified nursing staff work at these sites.

At the Woodbrook facility, additional specialist services in paediatrics, obstetrics and gynaecology, surgery, medicine, orthopaedics, ophthalmology have been added with elective surgery and low risk cases being admitted into its inpatient service.

Health Net employs 15 full time general practitioners and 3 dentists while specialists will be paid on a fee for service basis. Nurses are now being added to the staff complement. There has been no problem with recruiting staff, there has always been more applications than jobs. A Medical Director is also full time, and a Nurse Manager is to be added to the Management team. The Medical Director is responsible for quality, standards of care and management of medical staff.

Health Net's entry into the market stemmed from experience in the health insurance market when discussions on national health insurance in the early 90s made the senior managers in CLICO aware of the business potential in the coming years. There were also known issues of quality of care and petty abuse among its policy holders, so that it was envisioned that if CLICO could manage the provider end, then it would improve the cost efficiencies of the health insurance business.

Currently, Health Net provides care to the general public – about 50% of the clients who use services are covered by insurance. Prior to 1998, the ratio was about 20:80::insured:uninsured. There are plans to increase the network to 11 centres.

The most recent move has been to go into a joint venture with Medical Services Company, a private health provider from Canada. The latter will bring expertise in strategy and business development, services management, quality management, development of treatment protocols and training.

Marketing and Target markets

Marketing is done principally through local newspapers and media, personal recommendation and from marketing to doctors. Foreign users of the services are expected through the CLICO health insurance connection and they already provide some services to Guyana. No analysis is currently done of walk in users in terms of nationality.

Private Health Services Development

Routine data is not collected on private sector activity, and in the private sector, management systems are now being developed with the priority on financial management systems. There is however a sense of an increasing number of doctors and nurses working in the private sector, diagnostic centres, day surgery clinics, upgrading of doctors offices with more being done on an ambulatory basis and expansion on private hospital facilities. Private practitioners report seeing overseas patients from Guyana and Grenada on a regular basis for specialist and follow up care (almost as part of the shopping trip as West Indians seek care in Miami).

Cosmetic surgery is also being provided in Trinidad, with referral based on personal recommendation and professional referral and the patient recuperates usually in a friend's home – the patient usually enters as a normal tourist without restriction.

One relatively up market nursing home for the elderly has patients from Barbados and Montserrat, primarily because the price is good for the quality of service being provided. St Benedict's addiction programme also treats overseas e.g. patients referred from Cross Roads in Antigua, but it is not a major portion of the business as they are oversubscribed from the local market. There is a severe shortage of qualified and skilled therapists and nurses in both the public and private sectors, and those working in the private sector work mostly as individual practitioners although some physiotherapist have begun to network in terms of shared cover. Complementary Healing practice is also more prevalent now, as well as a number of drug stores carrying herbal treatments and homeopathic medicines.

A potential local private sector investor in health, in describing their experience of developing the project identifies the following internal barriers:

- Lack of incentives for investment in the health sector
- Poorly developed business and management perspective among health providers
- Fragmented framework for investment
- Lack of transparency in the process for approval of appropriate sites
- Lack of support from the public sector in terms of facilitating entry, joint planning and defining standards
- Lack of health specific management skills, this would need to be perhaps sourced externally
- Limited capacity to see larger implications of globalisation/liberalization of health market
- Control of the local market by doctors is a constraint in terms of efficiency

APPENDIX 3. List of Persons interviewed

<i>Agency/Institution</i>	<i>Contact person</i>
MoH	Dr Rosemarie Paul, Manager Policy and Planning Mrs Valerie Rawlins, Manager Quality Management
Ministry of Foreign Affairs and Trade	
TIDCO	Dr Carla Noel
ILO	Mr Reynolds Simons
PAHO	Dr Claudette Harry Dr Linda Campbell
CAREC	Dr James Hospedales Mrs Yvonne Roberts White
EWMSC	Dr Rasheed Rahaman
TRHA	Dr Maria Remy, Ag CEO Dr Eslyn Burris, Primary Care Services CEHO HSR Project Administrative Unit
THA	Mrs Agatha Carrington, Director Policy and Planning
Tobago Hilton	General Manager Marketing Manager
Kariwak Inn	Proprietor

Health Net

Mr A Guerrero, CEO

Dr Tennyson Sieunarine, Medical Director

Private Developer

Michael Scott

IDB

Ian Ho a Shu

IFC

Kirk Ifill

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