RESEARCH PAPERS

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LIBERALIZATION OF TRADE IN HEALTH SERVICES: BALANCING MODE 4 INTERESTS WITH OBLIGATIONS TO PROVIDE UNIVERSAL ACCESS TO BASIC SERVICES

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Acronyms

ACHPR	African Charter on Human and People's Rights
AMREF	African Medical and Research Foundation
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CEMAC	Economic and Monetary Community of Central Africa
CRC	Convention on the Rights of a Child
ECOWAS	Economic Community of West African States
EEA	European Economic Area
ENTs	Economic Needs Tests
ESA	Eastern and Southern Africa
ESC	European Social Charter
EC	European Commission
EU	European Union
GATS	General Agreement on Trade in Services
GATT	General Agreement on Tariffs and Trade
GDP	Gross Domestic Product
HIV/AIDS	Human Immuno Virus/Acquired Immune Deficiency Syndrome
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICN	International Council of Nurses
IOM	International Organization for Migration
ITNs	Insecticide Treated Nets
LDCs	Least Developed Countries
MDGs	Millennium Development Goals
MFN	Most Favored Nation
MRAs	Mutual Recognition Agreements
MTS	Multilateral Trading System

NGOs	Non Governmental Organizations
RQAN	Return and Reintegration of Qualified African Nationals Program
SSA	Sub Saharan Africa
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UK	United Kingdom
UNDP	United Nations Development Program
UR	Uruguay Round
US	United States
WHO	World Health Organization
WTO	World Trade Organization

EXECUTIVE SUMMARY

Health is a human Right. The Right is bestowed on human beings through national constitutions and various international legal instruments that have been signed and ratified by many, if not all, governments of the world. Inherent herein is the Right to access basic health services; which imposes an obligation on States to ensure that these services are universally accessible to all their constituents. Beyond the obligatory element, universal access to basic health services is also a development goal for which many governments strive to achieve. In a situation where the health sector in many parts of the developing world, particularly in sub-Saharan Africa, is in very weak condition, attempts of governments to deliver on this obligation face many challenges.

An increasingly important phenomenon in globalization is the movement of health service suppliers to provide services. While a lot of this movement takes place within and among developed countries, the trend between developing to developed countries is more concerning. As HIV/AIDS, malaria, tuberculosis and other treatable diseases continue to claim lives in untold proportions on the African continent, the exodus of health service suppliers raises serious issues, and has taken centre stage at various international fora.

In the context of the World Trade Organization (WTO) negotiations, developing countries, including the Least Developed Countries (LDCs) are ambitiously negotiating for enhanced market access in developed countries for the provision of services through the presence of natural persons (mode 4), including in the health sector. While the type of movement envisaged under the WTO is only a fraction of the channels through which health service suppliers move, it is an important one. Is ambition in mode 4 diametrically opposed to the attainment of universal access to basic services in the health sector? This Research Paper analyses this question.

In looking at the rules governing international trade in health services, particularly as they relate to presence of natural persons, WTO Members' market access and national treatment commitments on health services, trends in movement of health service suppliers, juxtaposed against the situation of the health sector in sub Saharan Africa, the paper sets ground for a discussion on implications of mode 4 on the health rubric of these countries, specifically on ability to provide universal access to basic health services. The paper aims, without purporting to have all the solutions, at identifying some policy options that governments can consider, so as to gain a level of balance between their interests in enhanced market access on mode 4 for health services, and the fulfillment of their obligations to provide universal access to basic health services. The paper argues that with concerted effort on the government policy side, countries can make inroads into striking this balance, and that the very nature of mode 4, particularly its conceptual and definitional meaning, may well be part of the solution.

I. INTRODUCTION

Many countries of the world, developing ones included, have got very strong ambitions on the increase in market access and national treatment commitments for the presence of their natural persons supplying services. At the higher chain of services industries, large corporate companies need to move their workers, in good time, to various subsidiaries across the globe, so as to heighten efficiency, competitiveness and profit margins. At the lower end of the industry, developing countries want to send their skilled and semi-skilled services suppliers to work temporarily in developed countries, so as to capitalize on the tremendous strength and benefit in the flow of remittances. The movement of natural persons to supply services is a very common phenomenon, particularly in the health sector. Doctors, nurses, and other health service suppliers are on the move in search for better opportunities than are available at home. In the WTO negotiations under the General Agreement on Trade in Services (GATS), developing countries are ambitiously pursuing enhanced market access and national treatment commitments from developed countries for provision of services through the presence of natural persons, including in the health sector. It is well known that the systems for providing health services in developing countries, particularly in sub-Saharan Africa (SSA) are stretched thin. In a situation where the community of the world's Nations has obligations, imposed by law on governments, to provide their people with universal access to basic health services, legitimate questions of concern arise, regarding what this ambition means for implementing these obligations. Is there a clash of interest and obligation? Are the two issues diametrically opposed? Such that attaining both is impossible? Can these countries deliver on the right to health enshrined in many of their national Constitutions, as well as in international legal instruments to which they are signatory, and in many cases have ratified, yet at the same time aggressively export health service suppliers to other countries?

This Research Paper looks at these questions, hoping to contribute to the process of finding optimal balances between this seemingly paradoxical situation. It starts with looking at trade in services and its sectoral importance. After covering definitional issues concerning the presence of natural persons (mode 4), universal access to basic services, and the right to health, the paper looks at the international legal regime governing trade in health services, placing the sector within the overall context of the GATS. The paper proceeds to scoping WTO Members' market access and national treatment commitments on mode 4 in the health sector, and the positions that developing and least developed countries have been taking in the GATS market access negotiations on this issue. The paper then takes a look at the health sector in developing countries, analyzing issues of capacity to provide health services universally in a domestic context. It then moves on to an analysis of the development implications of mode 4 in the health sector, particularly what this movement means for government's obligation to provide universal access to basic health services. In the chapter on balancing mode 4 commitments with providing universal access to basic health services, the paper offers some thought as to policy options developing countries may consider so as to achieve balance between interest and obligation. Here, the paper cites some examples of what has had some success in a few African and other countries, and then concludes with a reiteration of key findings.

II. TRADE IN SERVICES AND ITS IMPORTANCE

Trade in services is a new and dynamic activity that is continually making increasing contributions to the gross domestic product (GDP) calculations of many countries. In India, information technology-enabled services are responsible for a third of the total services exports. The value added in exports of services increased GDP growth by 0.2 and 0.6 percentage points annually over the 1980s and 1990s. In the Economic and Monetary Community of Central Africa (CEMAC), an annual growth rate of 6.5% is experienced in the services sector, contributing to GDP formation, with predominant sectors being distribution and transportation services. These sectors amount to an average of 65% of the production of services in the sub-region.[1] In the Economic Community of West African States (ECOWAS), Nigeria registers a contribution of 33.3% of the services sector to GDP, with key sectors being finance and insurance, as well as the energy sector arising from natural endowments of oil.[2] In Senegal, the services sector generates at least two-thirds of GDP, and is expected to continue growing, especially in the area of telecommunications.[3] Cote d'Ivoire has a diversified financial sector.[4] Cape Verde is particularly strong in transportation, travel and other commercial services.[5] In the Eastern and Southern African (ESA) region, World Bank statistics indicate that the services sector contributes up to an average of 50% to the GDP of many ESA countries.[6] In addition to all these figures, there are significant indirect effects on poverty reduction in the form of remittances from workers in foreign jurisdictions, domestic employment and direct and indirect consumption.

Services differ from goods in a number of ways, most commonly in the immediacy of the relationship between production and consumption. Because of this, it is generally accepted that, for the most part, services are non-stockable.[7] Technology has changed the previously accepted notion that there must be some degree of proximity between the consumer and supplier particularly in the new wave of business processing operations like outsourcing, data processing, telemedicine and various types of business consulting. The importance of trade in services extends from economic activity through the benefits people engaged therein get; such as in professional services and tourism, to the fulfillment of functions key to social wellbeing; such as health, education and water, as well as to the provision of inter-connectivity with other key sectors of the economy; such as agriculture and industry through distribution and transportation services. The labor-intensive nature of many services sectors (tourism, construction, business and health services) is a comparative advantage for several developing countries and can help to promote pro-poor growth.

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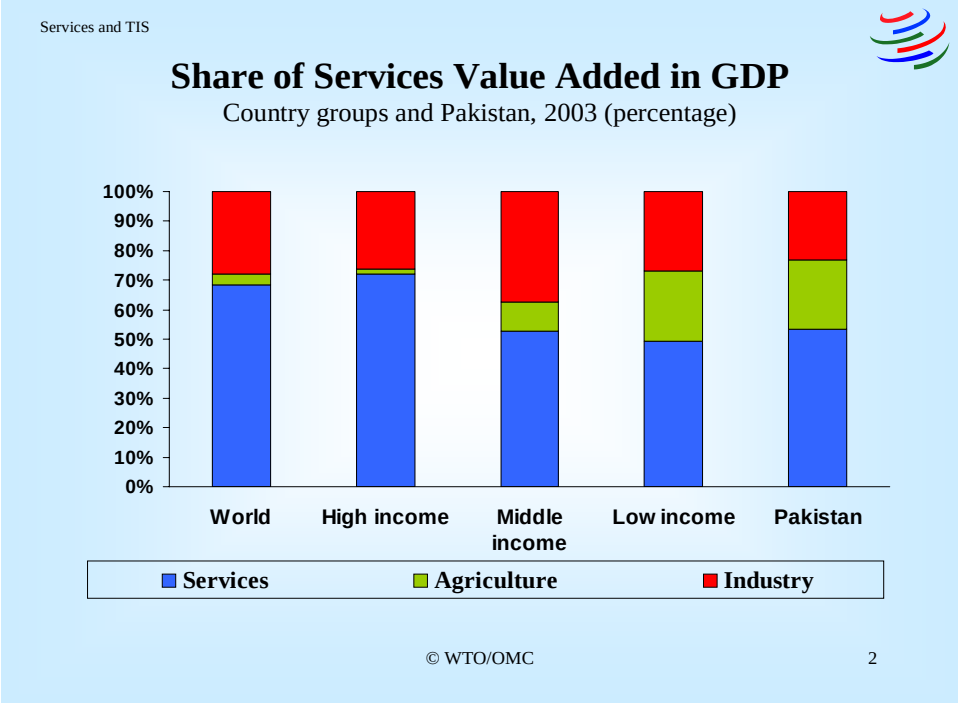
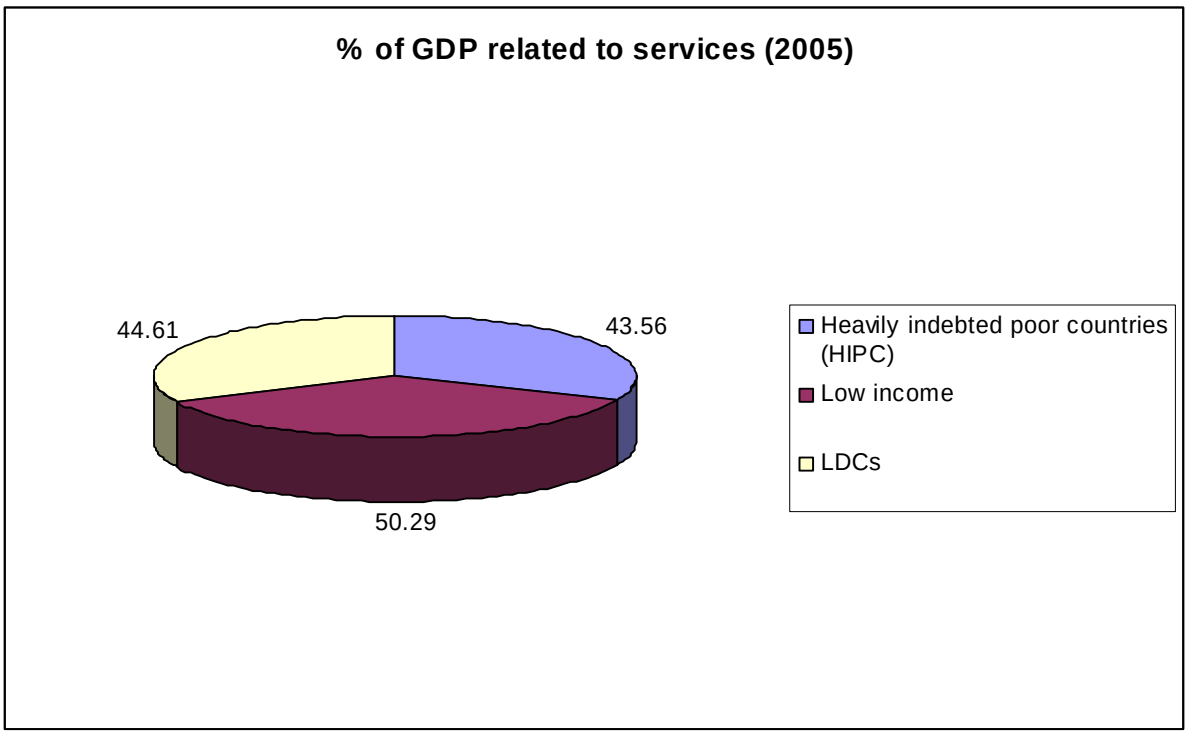
[1] Report of ILEAP workshop on trade in services negotiations, and trade facilitation in the Central African Economic and Monetary Union (CEMAC). On line available http://www.ileap-jeicp.org/.
[2] Country profile, 2007, Nigeria, The economist intelligence unit, www.london.eiu.com.
[3] Country profile, 2007, Senegal, The economist intelligence unit, www.london.eiu.com.
[4] Country profile, 2007, Côte d'Ivoire, The economist intelligence unit, www.london.eiu.com.
[5] ITC calculations based on COMTRADE and WTO statistics.
[6] World Bank WDI 2005, online available http://www.worldbank.org.
[7] With some exceptions for example the ability to store consultancy reports in USB keys.

Services represent the fastest growing sector of the global economy. In the table below, we see the share of services value added in GDP as at 2003.



The pie chart below shows sectoral contributions to GDP in poorer countries.



Source: World Development Indicators (WDI) database online, 2006.

III. THE PRESENCE OF NATURAL PERSONS (MODE 4)

There are many regimes that encompass the presence of natural persons supplying services, including temporary and permanent flows. They include, but are not limited to bilateral and multilateral trade and cooperation Agreements. While permanent migration is mainly a South-North phenomenon triggered by wage differentials and the expectation of living standard improvements, temporary flows are mainly the result of bilateral Agreements between governments wishing to foster co-operation. The GATS only covers a small fraction of the various options for persons moving to provide services, typically relating to movement within the framework of juridical persons, contractual service suppliers and independent professionals.

The GATS defines services on the basis of the way in which they are provided. In Article 2 (d) of the Agreement, one of the definitions is given as the provision of a service *by a service supplier of one Member, through presence of natural persons of a Member in the territory of any other Member*. This is otherwise known as mode 4. Further clarity on the exact parameters of mode 4 is provided in the Annex on the movement of natural persons supplying services under the Agreement.[8] The Annex clarifies that the Agreement only covers measures affecting natural persons who are service suppliers of a Member, and employees of a Member's service supplier, in respect of the supply of a service. It clarifies that the Agreement shall not ***apply to natural persons seeking access to the employment market of a Member, or to measures regarding citizenship, residence, or employment on a permanent basis.*** Regardless of their commitments therefore, Members still have scope to operate measures regarding citizenship, residence or permanent employment. Members can apply measures to regulate the entry of natural persons into their territory, including those necessary to protect the integrity of, and to ensure the orderly movement of natural persons across their borders, as long as such measures are not applied in a manner that nullifies or impairs benefits accruing to a Member on the basis of a specific commitment. The fact that a Member may require a visa for some and not other WTO Members as a condition for supplying the service is not construed as nullifying or impairing benefits under a specific commitment.[9] The Annex also provides that negotiations on mode 4 shall apply to the movement of ***all categories*** of natural persons supplying services under the GATS. Here below is a summary of the main features of what mode 4 entails under the GATS:

a) natural persons being service suppliers of a Member;

b) natural persons who are employees of a Member's service supplier;

c) movement is in respect of the supply of a service;

d) non-application to persons seeking access to a Member's domestic labour market;

e) non-application to measures affecting citizenship, residence or permanent employment;

f) negotiations under the Agreement are to extend to all categories of natural persons sup plying services under the Agreement;

g) Agreement does not preclude from a Member the right to regulate entry and stay of natural

[8] See Annex on the movement of natural persons supplying services under the Agreement. On line available, www.wto.org.
[9] Ibid.

> persons, except when such regulation is used to nullify benefits from a specific commitment.

From the definition of what is covered by mode 4, it is clear that the GATS, while an important tool in the creation of markets for health service suppliers, is not the only one. There are other avenues, typically bilateral Agreements, which cover movement of health service suppliers in a more expansive manner. However, if such Agreements contain mode 4 elements as defined in the GATS, in the absence of a Most Favoured Nation (MFN) exemption, or a GATS Article V curve out on services economic integration Agreements, the benefits accruing to WTO Members party to such bilateral Agreements would have to be extended to other WTO Members. However, there would be no question of WTO compatibility if these bilateral Agreements only bound government-owned hospitals, (because their foreign employees are beyond the definition of Mode 4), or if they involved companies sub-contracting the relevant services to government hospitals (where MFN, market access and national treatment do not apply in accordance with Article XIII (1) of the GATS, on government procurement).

While the distinction can be made between contract (which is often the case in the GATS), and employment (which is typically the case in the domestic labor market) based service provision, it is difficult to map out, with precision, mode 4 against existing categories of entry regimes in countries for the provision of services.[10] Even in the most advanced of migration systems, such as the United States (US) and Australia, problems still arise in identifying the precise regimes relevant to mode 4. For example, although temporary and permanent entrants are separated, no distinction is made in migration categories between service and non-service activities. It is also difficult to judge whether the activities covered under some visa categories are commercial within the meaning of the GATS. Rather than focus on this sometimes blurred difference, this paper will look at trends in the temporary movement of health service suppliers, challenges from a universal access to basic services viewpoint, and how governments can, through policy instruments, mitigate the negative effects on developing countries.

[10] For a further discussion on this, see Nielson and Cattaneo, 2003.

IV. THE CONCEPT OF UNIVERSAL ACCESS

There are some services whose use goes to the very core of the ability for human existence. The utility that their consumption has for human wellbeing makes them essential. Such services are a critical must-have for the social, economic and even political rubric of a country. Examples include health, education, water, e.t.c. It is a central obligation on, and sometimes a Right claimable from States, to ensure that their citizens have access to these services. Embedded in this is a citizen's Right to universal access to basic services.

There is a difference in concept between *universal service, universal access, essential, basic services, and universal service obligations.* In universal service, the issue is provision of a service to each person or household individually. The expectation of delivery and the amount of resources required for this is a lot higher, and the concept is very much used by developed countries.

Universal access on the other hand concerns the objective of ***providing everyone with access to a particular service, individually or collectively.*** The possibility of collectivity in receipt of a service makes this concept particularly relevant to developing countries. *Universal service obligations* are the minimum performance requirements that governments impose on service providers, so as to extend the scope of accessibility to services. The term *Universality* refers to availability, accessibility, and affordability.[11] The concept of "*universal"* is based on the notion that there is a universal human nature that creates a moral requirement to treat human beings in a certain way, by virtue of their being human. *Universal access to basic services* would therefore fit within this as an obligation that States have to ensure that their citizens have access to basic services.

According to the WHO framework for monitoring progress towards universal access, "access" is a broad concept which measures three dimensions of key health sector interventions: a*vailability, coverage and impact*. *Availability* is defined in terms of the *reachability* (physical access), *affordability* (economic access) and *acceptability* (socio-cultural access) of services that meet a minimum standard of quality. Making services available, affordable and acceptable is an essential precondition for universal access. *Coverage* is defined as the proportion of a population needing an intervention that receive it, and is influenced by supply (provision of services) and demand (from people in need of services). Coverage influences *Impact* of the intervention, which in turn is defined as reduced new infection rates or as improvement in survival.[12]

The terms *essential* or *basic* have sometimes been used interchangeably. They would mean those services that society must have in the pursuit of existence at all. The concepts vary depending not only on the type of service, but also the level of development of a country. In the case of health services for example, the level of what constitutes *basic* may vary. In SSA, *basic* may well mean access to treatment for malaria, tuberculosis, and HIV-AIDS. In this case, primary health care comes out as an important element of universal access. Governments would need to look at these concepts in light of their development levels.

The discussion on universal access to basic health services and the Rights it bestows on recipients is related to that on the Right to health-which refers to the Right to enjoyment of the highest attainable standard of health, and is a fundamental Right of every human being without distinction as to race, religion, political belief, economic or social condition. This Right is enshrined in various

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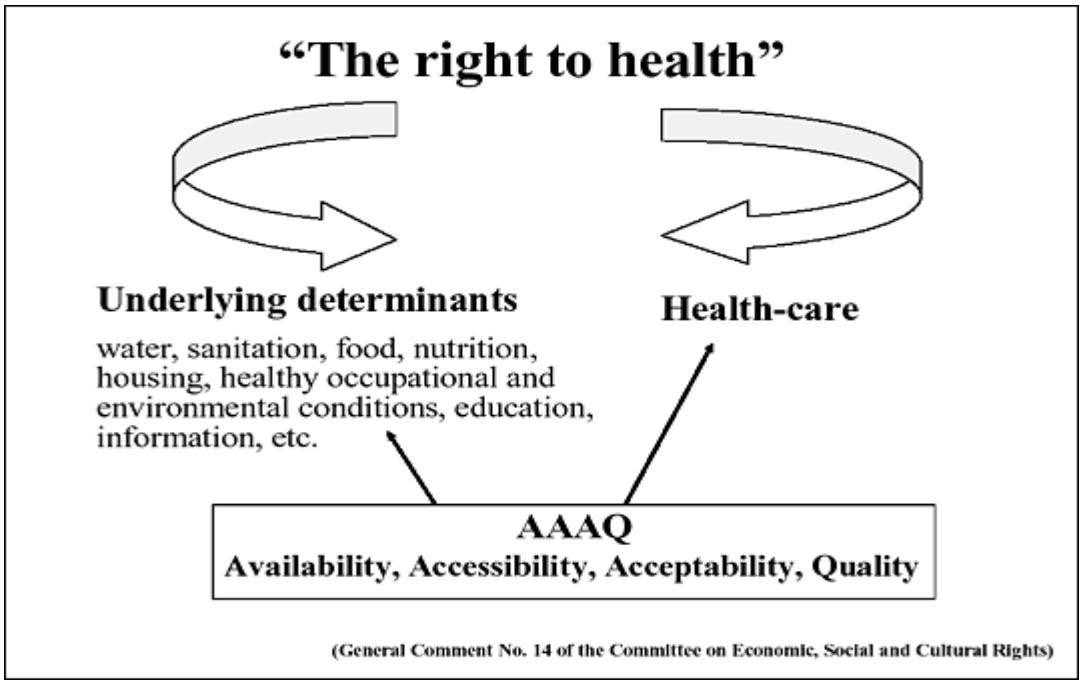
[11] See Wasunna, 2005.

[12] For more on universal access to basic/essential services, see www.who.int.

international legal instruments such as the International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966 , the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979, and the Convention on the Rights of the Child (CRC), 1989. Other regional human Rights Treaties that provide for this Right include the European Social Charter (ECS), 1961, the African Charter on Human and Peoples' Rights (ACHPR), 1981, and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (the Protocol of San Salvador), 1988.

The General Comment on the Right to health is also an important reference point, which suggests ensuring governmental responsibility and accountability for health under the human Rights framework in a structured way.[13] The General Comment serves as a guide for governments, particularly on issues of compliance with obligations under human Rights Treaties they have ratified. The document emphasizes availability, accessibility, acceptability and quality of health services. Most importantly, the Comment emphasizes the obligation of all governments to move deliberately towards making this Right a reality. The figure here below summarizes the content of the General Comment.



Source: http://www.who.int.

Developing countries face challenges in providing universal access to basic services, be it in the area of education, health, water, telecommunications or financial services. A major reason for this, particularly in smaller developing countries, and LDCs, is the absence of financial resources to invest into providing universal access to basic services. Difficulties also arise concerning the approach to regulation that governments can take in order to incorporate universal service obligations; whether they should only provide an oversight role, or engage more actively through *supply-side policy tools (*such as placing obligations on service providers) or *demand-side policy tools (*such as consumer subsides, involving government paying a percentage of the price of essential services such that the consumer only bears a minimal amount).[14]

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[13] The General Comment is published by the United Nations Committee on Economic Social and Cultural Rights, E/C, 12/200/4, No. 14, July 2000, and was produced by the Committee with input from WHO, and other governmental and non-governmental organizations with expertise in health.

[14] For more information on policy tools available across a broad range of sectors of essential services, see Universal Access to services, UNCTAD, TD/B/COM.1/EM.30/2. On line available http://www.unctad.org.

V. THE INTERNATIONAL LEGAL REGIME ON TRADE IN HEALTH SERVICES:

V.1. THE WTO'S GENERAL AGREEMENT ON TRADE IN SERVICES (GATS)

Trade in services was first introduced in the Multilateral Trading System (MTS) in the Uruguay Round (UR) of trade negotiations (1986-1994). The aim was to develop a framework Agreement that can govern international trade in services. The major demand for inclusion of services came from private sector interests in the United States (US) and the European Union (EU), both of which arguably have the best developed services infrastructure, markets and regulation in the world today. Developing countries were reluctant to include services in multilateral trade negotiations owing to their inexperience with the dynamics of services trade, weak infrastructure, and regulatory capacity. Their negative experience with unilateral liberalization of services sectors-particularly the failure to deliver welfare-enhancing results-was also a reason for this reluctance. Some developing countries also viewed the incorporation of services as an attempt to divert attention from areas of their core trade concerns such as improved market access for farm and textiles products.

The outcome of the UR was a legal framework of rules and disciplines on international trade in services, structurally more complex than the General Agreement on Tariffs and Trade (GATT) owing to the novelty in inclusion of consumer and factor movements that was necessary in view of the need in many sectors for suppliers and users to meet face-to-face. Being a framework Agreement, the GATS lays ground for future commitments through negotiations on progressive liberalization and, in some specified areas, the development of rules.[15] The GATS provides for rules on non- discrimination, i.e. most favored nation[16], national treatment[17] and transparency[18]. It also provides rules on domestic regulation[19], mutual recognition[20], general exceptions[21], guiding principles[22], specific commitments in schedules[23], compensatory adjustment in cases of withdrawal of concessions[24], dispute settlement provisions[25], denial of benefits[26], and others.[27] Successive Rounds of WTO negotiations, from Uruguay to Doha and beyond, aim at progressively increasing the levels of liberalization of trade in services, whose results would form part of the GATS.

As we have seen, the GATS defines a service from the view point of the mode in which it is provided; cross border[28], consumption abroad [29], commercial presence[30], and presence of natural

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[15] See Article XIX on progressive liberalization, and X, XIII, XV and VI: 4, which set mandates for negotiations on emergency safeguard measures, government procurement, subsidies and domestic regulation.
[16] See Article II of the GATS.
[17] See Article XVII, of the GATS.
[18] See Article III, of the GATS.
[19] See Article VI, of the GATS.
[20] See Article VII, of the GATS.
[21] See Article XIV of the GATS.
[22] Particularly on progressive liberalization in Article XIX of the GATS.
[23] See Article XX of the GATS.
[24] See Article XXI of the GATS.
[25] See Article XXIII of the GATS.
[26] See Article XXVII of the GATS.
[27] For further information on the provisions, see the GATS in *"The Legal Texts. The results of the Uruguay Round of Multilateral Trade Negotiations"*, Cambridge University Press, 1999.
[28] From the territory of one WTO Member into the territory of another. See Article I of the GATS.
[29] In the territory of a WTO Member to the service consumer of any other Member.

persons.[31] The first mode of supply (cross border) would include the provision of services that does not involve any physical movement of consumer or services supplier, for example through outsourcing, back office operations (such as call centres), provision of consulting reports, or legal opinions for consumers in another WTO Member. The second mode of supply (consumption abroad) includes a consumer leaving their country to consume a service in another WTO Member. The third mode of supply (commercial presence) includes provision of a service through setting up commercial presence, typically through foreign direct investment in the territory of another WTO Member. The fourth mode of supply (presence of natural persons) includes employees of a company temporarily entering the territory of another WTO Member to work in the company's subsidiary, contractual service suppliers moving to provide a service in the territory of another WTO Member on the basis of a pre-gained contract, or independent professionals and business visitors. Mode 4 has been identified by developing countries as constituting the greatest export and commercial interest for them.

The GATS allows WTO Members flexibility to select the sectors in which they wish to undertake commitments; fully or partially, and the conditions attached thereto. Members inscribe such limitations and conditions on market access, national treatment, undertakings relating to additional commitments, timeframe for implementation, or the date of entry into force of any commitment in a schedule of commitments.[32] The Agreement allows developing country Members to open fewer sectors, liberalize fewer transactions, progressively extend market access in line with their development situation, and when making access to their markets available to foreign service suppliers, to attach conditions aimed at achieving increased participation of developing countries in international trade as enshrined in Article IV.[33] The Agreement also allows Members to regulate in the public interest, and in line with national policy objectives.[34]

V.2. HEALTH SERVICES IN THE GATS

The GATS only covers measures taken by Members that affect trade in services.[35] Measures are defined as those taken by central, regional, or local governments and authorities, and non-governmental bodies in the exercise of powers delegated to them by central, regional or local governments and authorities.[36] Services which are supplied in the exercise of governmental authority i.e neither on a commercial basis nor in competition with one or more service suppliers, are excluded from the scope of the Agreement.[37] Typical examples of services that are provided in the exercise of governmental authority are police services, and the monetary operations of central banks. It may be argued that this exclusion precludes, in many instances, the GATS' application to the health sector, since most health services are provided by governments. However increasingly, health services are provided by private entities as well, arguably in competition with government in some cases. In such cases, the exemption would not apply. It is also true that many public services (including health), have since been unilaterally liberalized through privatization processes, owing to developing country responses to the International Monetary Fund' structural adjustment programs. Some countries have also taken commitments in their GATS schedules on various sub sectors of health services;

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[30] By a service supplier of one Member setting up commercial presence in the territory of another.
[31] By a services supplier of one WTO Member through presence of natural persons into the territory of another Member.
[32] See Article XX of the GATS.
[33] See Article XIX (2) and Article IV of the GATS.
[34] See Preamble to the GATS.
[35] See Article I (1) of the GATS.
[36]See Article I (3) (a) (i), and (ii) of the GATS.
[37] See Article I (3) (b) and (c) of the GATS.

highlighting the tradability, openness to competition, and commercialization of the service. As such, health services are very much part of the GATS.

Health services are usually provided via consumption abroad (mode 2) where a service consumer moves into the territory of another WTO Member to receive medical treatment, or through presence of natural persons (mode 4) where doctors and nurses move to provide medical services. There is also some scope for supply via cross border (mode 1) for example through telemedicine, where health diagnoses and analyses are supplied without any physical movement of either supplier or consumer. Telemedicine generally refers to the use of communications and information technologies for the delivery of clinical care or advice.[38] Increasingly, health services are also being provided through the set up of commercial presence (mode 3).

The sub-sectors that fall under the GATS in *Health related and social services* are hospital services and other human health services.[39] Other services which are also health related but fall under the sub-category of *Professional Services* are medical and dental services, services provided by mid wives, nurses, physiotherapists and para-medical personnel.[40]

In the health sector, Members would use their schedules of commitments to delineate the scope of their commitment. Some of the conditions they usually include are subjecting new entrants to economic needs tests, granting subsidies only to national suppliers, and providing for discriminatory universal service obligations on foreign companies. Below is an example of a schedule on health services.

Sector or sub sector	Limitations on market access	Limitations on national treatment	Additional commitments
Medical services	1) Unbound 2) None 3) None, other than the number of foreign-owned facilities registered each year may be limited depending on the total supply of doctors. 4)Unbound, except as indicated in the horizontal section	1) None 2) None 3) Non-accessibility of foreign owned medical facilities to government subsidies. 4) Unbound	

Members utilise the word *unbound* to mean that they do not commit market access or national treatment in that sector (sub sector, or mode concerned), and *none* to mean that there are no limitations. In the table above, under the **market access column**, the Member retains full policy discretion in mode 1, but commits not to retain discriminatory measures on market access in mode 2. In the case of mode 3, market access is conditioned on the fact that *the number of foreign-owned facilities registered each year may be limited depending on the total supply of doctors.* Possibly meaning that foreign presence through commercial establishment is designed to respond to the needs of the domestic situation particularly the availability of local doctors. In mode 4, the Member defers the details to the conditions of the *horizontal section;* a section normally used by countries to list the generally applicable restrictions that extend to the entire schedule of commitments.

In the **national treatment column,** for modes 1 and 2, the Member secedes the right to retain policy instruments that discriminate in favor of domestic service suppliers over foreign ones in the medical services sub-sector. In mode 3, the Member excludes the possibility of *foreign owned medical facilities benefiting from government subsidies*, while in mode 4, the Member does not

[38] On line available, http://en.wikipedia.org/wiki/Telemedicine.
[39] See UNCPC 9311, and 93191.
[40] See UNCPC9312 and 93191.

commit to treat natural persons providing health services like, or at par with domestic medical service providers.

V.3. SCOPING LIBERALIZATION COMMITMENTS ON MODE 4 IN THE GATS

Owing to sensitivities inherent in trading in health services, the health sector is one of those that have drawn the least commitments, particularly when compared to the total number of countries that have made commitments in other sectors of the GATS such as tourism. As at 2005, only 52 out of 137 WTO Members at that time, (counting EC 12 as one) had undertaken commitments on hospital services. Many large developed countries like Canada, Switzerland, Norway, Finland and Sweden have not undertaken any type of commitment in the health sector, with Canada making it clear that it will not undertake any access obligations on health services in whatever international forum. The EU is also unwilling to make further commitments beyond their current schedule. The only improvements that have been offered to date in the new Round of negotiations are from developing countries, with Jamaica and Thailand having signaled interest.

The table below shows the number of developed countries with commitments on individual health services as at June 2003.

DEVELOPING COUNTRY COMMITMENTS IN THE HEALTH SECTOR AS AT JUNE 2003

		Medical and Dental Services	Midwives, Nurses, etc.	Hospital Services	Other Human Health Services
TOTAL (out of 21 schedules)		18	17	15	2
MARKET ACCESS					
Mode 1	Full	4 (-1)	2 (-1)	0	0
	Partial	1	1	0	0
	Unbound	13	14	15	2
Mode 2	Full	5 (-1)	2 (-1)	14	0
	Partial	13	15	1	2
	Unbound	0	0	0	0
Mode 3	Full	2 (-2)	2 (-2)	0	0
	Partial	14	15	15	2
	Unbound	2	0	0	0
Mode 4	Full	0	0	0	0
	Partial	16	17	14	2
	Unbound	2	0	1	0
NATIONAL TREATMENT					
Mode 1	Full	4	2	0	0
	Partial	1	1	0	0
	Unbound	13	14	15	2
Mode 2	Full	5	2	14	0
	Partial	13	15	1	2
	Unbound	0	0	0	0
Mode 3	Full	1	2	13 (-13)	0
	Partial	16	15	2	2
	Unbound	1	0	0	0
Mode 4	Full	0	0	0	0
	Partial	17	17	14	2
	Unbound	1	0	1	0

Source: World Health Bulletin, November 2000/Rev.05 June 2003.Note: Individual counting for EC. Reduced number of full commitments if horizontal limitations are taken into account.

Of the health services sub sectors, medical and dental services are the most heavily committed (62 Members), followed by hospital services (52 Members) and services provided by midwives, nurses, etc (34 Members). Overall, this pattern suggests that it is politically easier or more economically attractive for the countries that make such commitments to liberalize capital-intensive and skills-intensive sectors than labour-intensive activities; a situation that has implications for the Mode 4 discussion, and which possibly explains the general blockage that developing countries are facing in the WTO with regard to mode 4 negotiations.

The table here below shows the situation for developing country commitments in the health sector as at June 2003.

DEVELOPING COUNTRY COMMITMENTS IN THE HEALTH SECTOR AS AT JUNE 2003

		Medical and Dental Services	Midwives, Nurses, etc.	Hospital Services	Other Human Health Services
TOTAL (out of 44 schedules)		44	17	37	20
MARKET ACCESS					
Mode 1	Full	17 (-1)	6	18	11
	Partial	11	5	1	1
	Unbound	16	6	18	8
Mode 2	Full	30 (-2)	10	30	15
	Partial	11	6	4	3
	Unbound	3	1	3	2
Mode 3	Full	16 (-3)	5	18 (-8)	13 (-4)
	Partial	23	10	16	7
	Unbound	5	21	3	1
Mode 4	Full	0	0	0	0
	Partial	40	15	34	19
	Unbound	4	2	3	1
NATIONAL TREATMENT					
Mode 1	Full	20	7	21	12
	Partial	9	5	1	1
	Unbound	15	5	15	7
Mode 2	Full	29	10	30	15
	Partial	10	6	4	3
	Unbound	5	1	3	2
Mode 3	Full	18	8	20 (-10)	11 (-3)
	Partial	21	7	13	7
	Unbound	5	2	4	2
Mode 4	Full	3	1	3 (-1)	1
	Partial	37	14	30	17
	Unbound	4	2	4	2

Source: World Health Bulletin, supra. Note: Includes central and eastern European transition economies. Reduced number of full commitments with consideration of horizontal limitations.

Once again, we see no full commitments in mode 4, as well as very limited partial bindings. Still, we see most of the commitments for developing countries being in the area of medical and dental services, with the sub sectors of midwives and nurses attracting the least commitments both in market access and national treatment.

A comparison of schedules from the modal perspective shows that mode 4 is the least liberalised of all. No WTO Member has undertaken full commitments in any of the four health sub sectors on mode 4. As in all other services, commitments for this mode are subject to highly restrictive limitations. Many WTO Members have limited their mode 4 commitments to very highly skilled suppliers possessing knowledge that is hardly available in the domestic context such as

contractual service suppliers-linked to commercial presence-with very high minimum qualifications. In contrast, mode 2 in health services is quite liberalized, possibly because the service is consumed outside a country! Most developed countries have no limitations particularly on market access in this mode. In such a case, such countries commit themselves not to deter their residents from travelling abroad to consume health services. However, many of these countries also retain some restrictions on national treatment particularly on discriminatory taxes and non extension of national insurance schemes to services consumed abroad. Mode 1 registers high non-bindings, limiting scope for new developments such as in telemedicine.

V.4. THE ROLE OF THE HORIZONTAL SECTION IN MODE 4 COMMITMENTS

Most GATS commitments on presence of natural persons are horizontal in nature. The horizontal section, which typically comes first in a schedule of commitments, provides the rules that will apply to all sectors included in the schedule. In the sector specific column, Members provide details, sector by sector, of the limitations and conditions on market access and national treatment that will apply to each commitment. For mode 4, Members will usually list the categories of natural persons that can access their markets under this mode. Traditional examples of such categories are intra-corporate transferees (who may include managers, specialists and sometimes graduate trainees) business visitors (who may include service sellers and those involved in the setting up of commercial presence) contractual service suppliers and independent professionals.

Members also use the horizontal section to express the yardsticks that service suppliers have to meet in order to access their markets. In the category of intra-corporate transferees for example, a Member may state that a manager has to be at senior level, within a juridical person, primarily responsible for directing the establishment's management, in order to qualify. A Member may also provide that for one to qualify as a specialist, he/she must possess uncommon knowledge essential to the establishment of the service. In the EC schedule for example, for a service supplier to access the market as an intra corporate transferee and business visitor, he/she has to fulfill the conditions set out in the horizontal section, i.e. work within a juridical person and be temporarily transferred to the subsidiary in the territory of another Member, either at managerial or specialist level.[41] The countries of Cyprus, Czech Republic, Finland, Malta, Sweden and Slovak Republic exclude themselves from commitments for this category of persons. In the sub sector of ***other human health services*** (such as those provided through residential health services like health resort hotels and therapeutic bath services)[42] most of the EC Member States except Austria, Estonia, Hungary, and Slovenia, (which defer the extent of commitment to the horizontal schedule) have not scheduled commitments for intra corporate transferees and business visitors. In the sub-sector on ***social services*** (which may include old people's homes, and rest houses) all EC Member States, with the exclusion of the Czech Republic, Finland, Hungary, Malta, Poland, Sweden, Slovenia and Slovak Republic (which do not make commitments) condition their market access and national treatment commitments for intra corporate transferees and business visitors to provisions in the horizontal part of the schedule. The same situation exists for the sub sector of ***medical, dental and midwives services,*** where access for intra corporate transferees and business visitors is conditioned on the horizontal part (with some more country specific limitations such as for the Czech Republic, Estonia, Hungary, Slovenia and Slovak Republic, which do not commit to market access for midwife services, and Germany, which has a nationality condition for doctors and dentists, with a waiving possibility on exceptional basis). Similarly, in the sub sector of ***services provided by nurses***, ***physiotherapists and paramedical personnel,*** all EC Member States, (with the exception of Czech Republic, Hungary, Malta, Estonia and Cyprus which do not make commitments) attach the horizontal section conditions on market

[41] See EC schedule of specific commitments TN/S/O/EEC/Rev.1. On line available, http://www.wto.org.
[42] For example UNCPC 93193.

access and national treatment to their commitments for intra corporate transferees and business visitors. Poland, Portugal and Greece also condition market access on nationality.[43] In light of such specifications, for the health sector, only persons fulfilling such requirements are considered eligible for purposes of mode 4.

Some of the limitations that may appear in Members' schedules include quotas, training, language, residency and nationality requirements, standards, and economic needs tests (ENTs). The latter is mostly applicable to hospital services but also medical and dental services, sometimes based on population density, age structure, death rates, and the number of existing facilities. Other limitations relate to qualifications.[44] There are some MFN exemptions, particularly for medical, dental and/or human health services. However, a number of MFN exemptions that are not sector-specific may also be relevant to health services, including guarantees under bilateral investment protection Agreements or tax preferences for certain nationalities.

The table below shows the overall specific commitments of WTO Members on individual health services as at June 2003.[45]

SPECIFIC COMMITMENTS OF WTO MEMBERS ON INDIVIDUAL HEALTH SERVICES, JUNE 2003

Members	Medical & Dental S.	Nurses, Midwives etc.	Hospital Services	Other Human Health S.	Members	Medical & Dental S.	Nurses, Midwives etc.	Hospital Services	Other Human Health S.
Albania	X	X	X	X	Kyrgyz Rep.	X	X	X	X
Antigua & Barbuda	X				Latvia	X	X	X	
Armenia	X		X	X	*Lesotho	X	X		X
Australia	X			X	Lithuania	X	X	X	
Austria	X	X	X	X	Macedonia	X	X	X	X
Barbados	X				*Malawi	X	X	X	
Belize	X			X	Malaysia	X		X	X
Bolivia			X		Mexico	X	X	X	
Botswana	X	X			Moldova	X	X	X	
Brunei Darussalam	X				Norway	X	X		
Bulgaria	X				Oman	X		X	
*Burundi	X		X	X	Pakistan	X		X	
China	X				Panama			X	
Chinese Taipei			X	X	Poland	X	X	X	
*Congo RP	X				Qatar	X			
Costa Rica	X		X		*Rwanda	X			
Croatia	X	X	X	X	Saint Lucia			X	
Czech Republic	X				Senegal	X			
Dominican Rep.	X		X	X	St. Vincent			X	X

[43] See EC schedule, supra.

[44] Recognition of qualifications is a major obstacle to provision of services under mode 4. By May 2003, WTO had received 38 notifications of recognition measures under the relevant provisions (Article VII: 4 of GATS). Of these notifications, 17 were potentially relevant for health services; they were submitted by Latvia, Macau, Switzerland and several Latin American countries and concerned the recognition of diplomas.

[45] Annex 1 shows the overall number of Members that have commitments in market access and national treatment terms.

Members	Medical & Dental S.	Nurses, Midwives etc.	Hospital Services	Other Human Health S.	Members	Medical & Dental S.	Nurses, Midwives etc.	Hospital Services	Other Human Health S.
Ecuador			X		*Sierra Leone	X	X	X	
EC (12)	X	X	X		Singapore	X			
Estonia	X		X	X	Slovak Republic	X			X
Finland		X			Slovenia	X		X	
*Gambia	X	X	X	X	South Africa	X	X		
Georgia	X		X	X	Swaziland	X		X	
Guyana	X				Sweden	X	X		
Hungary	X		X	X	Switzerland	X			
India			X		Trinidad & Tobago	X		X	
Jamaica	X	X	X		Turkey			X	
Japan			X		USA			X	
Jordan	X	X	X	X	*Zambia	X	X	X	X
Kuwait			X	X	TOTAL	62	34	52	22

*Source: World Health Bulletin, supra. Note: * refers to LDCs.*

V.5. DEVELOPING COUNTRY AND LDC POSITIONS IN THE GATS DOHA ROUND NEGOTIATIONS ON MODE 4

The above table corroborates our earlier assertion that mode 4 commitments in health services are minimal. Because of this, developing countries have been pursuing enhanced market access and national treatment commitments in the Doha Round of GATS negotiations. The group of developing countries led by India tabled a plurilateral request on mode 4 in which they seek enhanced market access and national treatment commitments on mode 4 de-linked from the need to have commercial presence (mode 3) for the categories of independent professionals and contractual services suppliers.

The group of LDCs also seek enhanced market access and national treatment commitments for contractual service suppliers, independent professionals, business visitors, and 'others', beyond those that possess very high skills, in various sectors including *health and related social services*.[46] Detailed sectors and sub-sectors of this request are in Annex B to this paper. The table below shows some thematic features of the LDC revised request on mode 4.

THEMATIC FEATURES OF THE LDC REVISED REQUEST ON MODE 4

- Sets out a broad list of sectors;
- Liberalisation de-linked from commercial presence;
- Extension of commitments beyond high minimum qualifications.(To include diplomas, and experience);
- New ways to assess competencies beyond university degrees. (Such as demonstrated experience);
- Acceptance of substitutable options (diplomas, university degrees, or demonstrated experience, specialised certificates, certificates of proficiency, e.t.c);
- Exclusion of wage parity as a pre-condition of entry;
- Direct receipt of remuneration by services supplier;

[46] See JOB (06)/155.

- Substantial reduction of quantitative restrictions;
- Substantial reduction of ENTs;
- Option of contract renewal;
- No direct employment on domestic market;
- Acceleration of verification and recognition of skill, competence and qualifications within 3 months;
- Setting up skills testing facilities within 6 months of Doha Round completion.
- Commitments sought for Independent Professionals, Business Visitors, Contractual Services Suppliers, and 'others'.

The LDC request, (as compared to the developing country plurilateral request on Mode 4) seeks to cover semi-skilled professionals by broadening the scope of service suppliers whose competencies and qualifications may meet the yardsticks set for independent professionals, business visitors, and contractual services suppliers. It sets out *common definitions and parameters of Independent professionals and contractual services suppliers* as those that will possess appropriate educational and professional qualifications such as diplomas, university degrees or demonstrated experience, presented as substitutable options.

In the category of ***"Others",*** LDCs seek to widen commitments to include such categories as Installers and services[47], Graduate trainees[48], Personnel of public or private enterprises in another WTO Member with a State contract in the host country[49], Persons of internationally recognized reputation[50], artists, sportsmen (and women)[51] and fashion models.[52] The requirements for certain of these categories are expanded to include holders of certificates of proficiency as well. By targeting flexible horizontal definitions, the group aims at increasing scope of sector specific coverage.

In the area of health services, LDCs seek market access and national treatment commitments for independent professionals, contractual service suppliers, business visitors, installers and servicers, graduate trainees and personnel of public or private enterprises. These commitments are sought in the sub sectors of medical and dental services, nurses, physiotherapists and para-medical personnel. Beyond these, LDCs seek commitments for hospital services and other human health services.[53] By presenting broader definitional parameters for the horizontal schedule, the group aims at increasing the scope of service suppliers that can benefit from sector specific market access and national treatment commitments from WTO Members.

In this chapter, it has come out clearly that developing countries are very much engaged in the negotiations for enhanced market access and national treatment commitments on mode 4 under the GATS. In other words, these countries are ambitiously pursuing market openings so as to temporarily

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[47] Who would be foreign-based natural self employed persons that enter into the territory of another Member to install or service machinery and/ or equipment for a service mentioned in the commitment of the host country.
[48] These would include non-resident natural persons with a diploma, university degree or post-graduate qualification who enter or remain in another WTO Member territory pursuing post graduate work for the purpose of obtaining appropriate work experience, business techniques or methods of a service mentioned in the commitment of a Member.
[49] This would include employees of a foreign based private or state enterprise who enter the territory of another WTO Member temporarily in order to perform a service contract (s) between their employer and a State or government.
[50] Who are invited to educational institutions, scientific research institutes, public educational institutions, and non-governmental organizations.
[51] Taking part in public or private performances.
[52] Participating in competitive or non-competitive events.
[53] Although they do not indicate what these other human health services are, usually these may refer to ambulance services and residential health facility services.

supply health services to other WTO Members. The following chapter takes a look at the health sector on the ground situation in these countries.

VI. A LOOK AT THE SITUATION OF THE HEALTH SECTOR IN AFRICA

Health is an essential service. Health services provide the means for dispatching the tools and supporting strategies needed to combat infectious diseases, as well as life-saving interventions to those at greatest risk. For many years, government has been the major provider of health services, along with other essential services such as education, water, and electricity. However the situation is changing with notable inclusion of private providers of health services in many countries.

The health sector is one of the faster growing sectors in the world economy, evidenced through increased cross-border delivery of health services (e.g. through telemedicine) consumption abroad (e.g. through the influx of patients into India, South Africa, and Hong Kong-China for medical treatment) commercial presence (e.g. the presence of Cuban and Chinese doctors in Africa, who have set up commercial facilities) and through movement and presence of medical personnel supplying health services (e.g. doctors, nurses, physiotherapists, carers, etc).

While the sector develops, challenges remain with public health services facilities in developing countries such as government referral hospitals and clinics. Many of these facilities are poorly equipped to provide services that meet the basic health needs of their populations. The availability of health care providers: from specialists to general practitioners, from nurses and midwives to medical assistants, is limited. The level of specialized skill in the treatment of diseases relevant to these countries is not at its highest potential; a situation that is worsened by limited amounts of usable tools and implements to assist in carrying out of day to day health care duties. The number and spread-out of government referral hospitals and clinics, in terms of proximity to domestic dwellings is limited, getting worse in rural areas. Morale is low and salaries meager. Disease surveillance and reporting systems function minimally, making it difficult to identify disease outbreaks and respond to the most urgent health needs.[54]

The situation is particularly worse in SSA; a region confronted with unprecedented health crises; a disproportionate burden of preventable diseases largely rooted in poverty and a weak health system. There is a shortage of resources for health services, frequently underfinanced, with external assistance accounting for a large share of government health budgets.[55] In the period between 1980 and 1998, the areas of fuel and energy, mining, manufacturing and construction, general administration and defense accounted for more than 50% of total government spending in Africa, with health expenditures attracting minimal budget allocations.

Beyond the problem of small budgetary allocations is that of location and therefore accessibility of health services across a country, with more than 60% of government health spending devoted to urban hospitals serving just 10% of the population.[56] In Ghana for example, the more affluent population account for three times more public health spending than the poor.[57] In 10 developing countries, between 1992 and 1997, only 41% of poor people suffering from acute respiratory disorders, including tuberculosis (TB) were treated in a health facility compared to nearly 60% of the affluent.[58] In the same period, only 22% of births among the poorest 20% of people were attended by medically-trained staff, compared to 76% among the richest 20%.[59]

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[54] See WHO: "Health Services", http://www.who.int/infectious-disease-report/2002/healthservices.html.
[55] See WHO: Scaling up the Response to Infectious Diseases, 2002.
[56] Ibid.
[57] Ibid.
[58] Ibid.
[59] Ibid.

The Situation in Malawi: *Excerpts of an interview with a medical officer*

> Fred Zayinga is a senior clinical officer in Chikwawa District, situated in the densely populated south of Malawi. Chikwawa District hospital has 300 beds and covers one 50-bed rural hospital and 20 health centers. Health centers are staffed by medical assistants, nurses and increasingly because of staff shortages, health surveillance assistants. In an interview with Mr. Zayinga, he explained that monthly supervisory visits to the clinics had for the past year been curtailed because of staff shortages and delays in receiving their travel budget. Non-emergency surgery has been stopped at the district hospital for about six months because of lack of equipment and supplies such as gauze and cotton wool. The laundry equipment broke down six months before. The equipment had also recently broken down in Nsanje hospital, some 100 km away, where laundry had been sent as an interim measure. Moreover, the workload had increased greatly in recent years, with HIV and AIDS being largely responsible. More recently, drought had led to many more cases of severe child malnutrition. The new antiretroviral treatment programme had created additional challenges. "Things are worse than in the 1980s: they started going downhill in the 90s, and got worse when nurses started leaving for the UK about five years ago," Mr Zayinga said. "There has also been internal robbery by external funders and the mission hospitals, which pay better." [60]

Of the nearly 11 million children worldwide aged less than 5 years dying every year from treatable diseases, most live in developing countries, with more than four million of these deaths in SSA.[61] Along with the disastrous effects of warfare, HIV/AIDS is wiping out young adults, including health professionals, leaving young children in the care of siblings and grandparents, posing further strain on health systems. Lack of basic drugs, supplies, equipment, personnel and the overall issue of access, quality and affordability, all affect the functionality of the health system.[62]

In the case of the HIV/AIDS pandemic, lack of medical staff is one of the biggest obstacles to providing patients with anti-AIDS drugs. Southern Africa, which is very hard hit by the AIDS epidemic, accounting for the vast majority of the 40 million infections and the daily death toll of 8000 lives, has many people still waiting for treatment.[63] South Africa for example has 393 nurses and 74 doctors per 100 000 people, with a high percentage working in the private sector and acute shortages in rural areas. This, compared to the 901 nurses and 247 doctors per 100 000 people in the US, is telling of the magnitude of the problem.[64] In Thyolo district of Malawi, a single medical assistant can see up to 200 patients per day. In Mavalane district in Mozambique, many patients died during a two month wait period to start treatment because of a lack of doctors and nurses. In one of Lesotho's main hospitals, more than half the professional nursing posts were vacant.[65]

This notwithstanding, there is a continual movement of health service suppliers, particularly doctors and nurses, to richer countries. Some of the reasons that make moving abroad attractive are poor promotion possibilities at home, inadequate management support, heavy workloads, limited

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[60] See "Confronting Africa's health crisis: more of the same will not be enough". On line available, http://www.bmj.com/cgi/content/full/331/7519/755.
[61] Department for International Development. Millennium development goals. Child mortality. Online available, http://www.dfid.gov.uk/mdg/childmortalityfactsheet.asp.
[62] Zewdie 2005.
[63] Ibid.
[64] Ibid.
[65] Ibid.

access to good technology and even to medicines. These are often cited as "push factors" motivating health workers to leave their country of origin.[66] Such problems are intensified in rural areas, where health workers feel they and their institutions are too often ignored by the government, owing to the urban bias in development policy.[67]

Economic benefit is a critical attraction, with higher earnings being an important consideration for many. The attraction of more money is not only limited to SSA health service suppliers. Filipino nurses' earnings show figures ranging from 75 to 200$ per month in the Philippines compared to between 3000 and 4000$ per month available in the US. For highly skilled workers, professional development is an important consideration. Kingma (2001) reports the findings of a survey undertaken by the International Council of Nurses (ICN) that examined the incentives and disincentives to nurse migration. The strongest incentive cited by respondents was the availability of learning opportunities. This includes scope to acquire specialist training that may not be available in the home country or similarly the chance to use technologies and other equipment which is not routinely available at home.

Patterns of health worker movement from SSA have changed substantially over the last 30 years. In their 1970s study, Mejia et al[68] found that health workers moving abroad were from a relatively small number of African countries (larger ones like South Africa, Nigeria and Ghana) and they predominantly went to a few developed countries outside Africa. Since then, movement has become much more complex, involving almost all SSA countries, particularly Ethiopia, Angola and Uganda. There is also intra-regional and stepwise movement (for example, from the Democratic Republic of Congo to Kenya and from Kenya to South Africa, Namibia and Botswana). Increasingly, this movement is resulting from targeted recruitment by agencies and governments, as well as individual volition. Various other reports suggest similar growth in numbers and proportions.[69]

Empirical studies generally confirm that the majority of health workers moving from developing into industrial countries are better educated than the average workforce remaining behind. This is in line with prevailing patterns of GATS commitments, wherein recipient countries tend to offer market access only for very highly skilled professionals. Another general feature is that movement tends to be selective, with the younger and better educated health professionals being more mobile than older ones.

Data presented in the 2006 World Health Report strongly supports the direct link between positive health outcomes and the density of professional health care workers. The evidence highlights the difficulty in reaching targets where health systems are experiencing critical staff shortages. Countries having the greatest difficulty in meeting the UN Millennium Development Goals (MDGs) are faced with absolute shortfalls in their health workforce, seriously limiting their potential to respond equitably even to basic health needs.

With this as the situation, a cause for concern arises when these countries continue to lose a valuable resource of trained doctors and nurses. Some have argued that even the aid given from rich countries makes limited impact and sense in a situation where there are no health professionals to treat these diseases locally.[70] According to the 3 by 5 initiative, large parts of SSA have effectively no health care at all, with only 600 000 healthcare workers for a population of 682 million.[71] Many of

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[66] Bach 2003; Buchan et al 2004; Kingma 2006; Muula & Maseko 2006.
[67] Dussault & Franceschini 2006.
[68] Mejia et al. 1979.
[69] Hagopian et al. 2005.
[70] Department for International Development. Millennium development goals. Child mortality, ibid.
[71] The 3 by 5 Initiative. *Preventing and treating HIV/AIDS in poor countries will help deliver better health services through 2005 and beyond*. 1 November 2004. On line available, http://www.who.int/3by5/mediacentre/news27/en/.

these health professionals get frustrated with this situation and leave for a better life in richer countries. It is reported that only 60 of the 500 doctors trained in Zambia since independence are still there.[72] In Cameroon, the ratio of health professionals per acre is 1: 400 in urban areas and 1: 4000 in rural locations, requiring rural dwelling occupants to travel long distances in order to find health care. This kind of imbalance is just as severe in Angola, where 65% of the population live in rural areas but only 15% of health workers are, the vast majority of these having opted for better-paid jobs in urban areas.[73] Health professionals from Commonwealth developing countries, usually fill manpower gaps in english speaking developed countries such as the US, Canada, the United Kingdom (UK), New Zealand and Australia, owing to their ability to communicate.[74] In some countries, even where trained health staff is in place, primary care centers and district hospitals lack adequate facilities to diagnose infections and repeatedly run out of medical supplies and drugs. For example in Zambia, where the number of TB cases increased six-fold between 1992 and 1998, proper treatment was hindered because health facilities kept running out of TB drugs.[75]

The shortage of domestic health workers is not only seen in African countries. The Philippines is very active in exporting health service suppliers, and plays a central role in the political economy of migration, with an estimated 7 million Filipinos (approximately 10% of the population) working or living abroad. This reflects the country' historical evolution in which high levels of unemployment led the Philippines Government to encourage labor migration, initially with large outflows of doctors to the US. The initial trend of movement by doctors has since been supplemented by nurses and the country is the largest source of registered nurses working overseas. This policy has been incorporated into government planning, viewing overseas employment as a key source of economic growth. As the Philippine Secretary of Labor and Employment commented, "It's an industry. It's not politically correct to say you are exporting people, but it's part of globalization, and I like to think that countries like ours, rich in human resources, have that to contribute to the rest of the world".[76] Over 70% of the 7 000 nurses who graduate each year leave the country, and this contributes to the annual estimated outflow of 15 000 nurses per annum bound for more than 30 countries.[77] It has even been suggested that doctors are re-training as nurses because of the greater opportunities available for employment abroad.[78] However, as noted by the OECD[79], the Philippines confronts a shortage of nurses, estimated at 30 000 unfilled nursing positions within the Philippines.

A bigger problem is that in SSA, most of the movement is not managed or structured, many times having limited government involvement. Health service suppliers simply leave when opportunity arises. While this exodus takes heightened levels, the glaring health crisis looms. Recalling that availability, coverage and impact are critical must-haves for universal access to basic health services, it is clear that developing countries, particularly those in SSA face grave challenges in meeting this obligation. What then are the more specific development implications of mode 4 on this situation? The next chapter delves into this.

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[72] Development Gateway. *Capacity development for MDGs. Rising to the challenges: the millennium development goals for health*. On line available, http://www.bmj.com/cgi/content/full/331/7507/2?ecoll12
[73] See WHO, Scaling up the Response to infectious Diseases, supra.
[74] Ibid.
[75] Ibid.
[76] For more information on the exodus of Filipino nurses, See http://allnurses.com/forums/f195/sapping-philippines-health-care-system-69825.html.
[77] Adversario 2003.
[78] Sison 2003.
[79] See OECD, 2003.

VII. IMPLICATIONS OF MODE 4 FOR OBLIGATIONS TO PROVIDE UNIVERSAL ACCESS TO BASIC HEALTH SERVICES

As we have seen, there are challenges with the health system in many developing countries, particularly in SSA-from the view point of ability to deliver on obligations to provide universal access to basic health services. Availability, accessibility and affordability all score poorly. We have also seen that developing countries and LDCs are pursing an ambitious mode 4 agenda in the WTO services negotiations, including in the area of health services through the plurilateral and LDC joint request on mode 4.[80] In this part of the paper, we look at what the possible implications are, from a development perspective, on the ability of these countries to provide universal access to basic health services.

Most of the categories of natural persons that can provide services under the GATS operate under a juridical person, in the context of private law, which makes it difficult to capture with precision the exact flows of mode 4 overall, and more so in the health sector-thereby creating difficulty in ascertaining the impact in number terms, on African countries and SSA in particular. Many times, foreign direct investment information is used as a proxy for mode 4 calculations, but legitimate issues arise as to the veracity of the results of this approach. Data collection is even harder in the case of independent professionals who provide services in a self employed capacity on the basis of an obtained service contract.[81] While the Annex on the movement of natural persons is clear, in so far as it sets out parameters for mode 4 such as non-encroachment on domestic labor market, in practice, this line may not be so clear.[82] In the African region, as is the case with many others, credible data on presence of natural persons supplying health services under the GATS is scarce. As such, it is difficult to capture mode 4 separate from persons employed in the domestic health services market, who strictly speaking, would not be covered under the GATS.

This notwithstanding, there is some scanty information, such as on South Africa, where Martineau et al (2002) report that almost 80% of rural doctors were non-South African in 1999. Such foreign employees, if employed by foreign owned health facilities, or if they hold pre-gained contracts in an individual capacity, would be covered under mode 4. In Alberta Canada, South African doctors have been recruited to work in rural areas that are not attractive to Canadian nationals.[83] To the extent that these foreign employees work in foreign owned health facilities, are employees of foreign companies, or are independent professionals-and therefore foreign service suppliers, they are covered by mode 4. South Africa has become an important source country for nurses, indicated by the number of nurses seeking verification of their qualifications before applying for overseas employment, which increased from 511 in 1995 to 2,543 in 2000.[84] The flow of nurses from South Africa has increased eightfold since 1991 and well over half of these leave for the UK which has historically been a major destination country for doctors and nurses particularly from english speaking Africa and the Caribbean. In 2002 over 200 000 doctors held provisional, full or limited registration in the UK. In

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[80] Plurilateral requests are by nature informal documents, as such, there is no official citation for them. The request was co-sponsored by Argentina, Brazil, Chile, China, Colombia, Egypt, India, Mexico, Pakistan, Peru and Thailand. The LDC request can be found in JOB (06)/155.

[81] For an overview of temporary movement of natural persons, see: Information on the temporary migration regime (laws and implementing regulations) in force in selected developed countries, note by the UNCTAD secretariat, UNCTAD/SDD/SER/7, 1995.

[82] See Annex on the Movement of natural parsons supplying services under the Agreement. Online available http://www.wto.org.

[83] Bundred & Levitt 2000. Also see Regional Committee for Africa: Poverty, Trade and Health: An Emerging Health Development Issue, 2006.

[84] Xaba & Phillips 2001.

terms of full registration over half were trained in other countries, especially outside the European Economic Area (EEA).[85] The number of nurses is even higher than doctors, with about 18 000 Zimbabwean nurses working abroad.[86]

The table below shows the number of overseas-trained nurses registered per annum in the UK 1998-2003.

COUNTRY REPRESENTATION OF OVERSEAS TRAINED NURSES IN THE UK

COUNTRY	1998-99	1999-00	2000-01	2001-02	2002-03
Philippines	52	1 052	3 396	7 235	5 594
India	30	96	289	994	1 833
South Africa	599	1 460	1 086	2 114	1 480
Australia	1 335	1 209	1 046	1 342	940
Nigeria	179	208	347	432	524
Zimbabwe	52	221	382	473	493
New Zealand	527	461	393	443	292
Ghana	40	74	140	195	255
Pakistan	3	13	44	207	172
Kenya	19	29	50	155	152
Zambia	15	40	88	183	135
US	139	168	147	122	89
Mauritius	6	15	41	62	60
West Indies	221	425	261	248	57
Malawi	1	15	45	75	57
Canada	196	130	89	79	53
Botswana	4	-	87	100	42
Malaysia	6	52	34	33	27
Singapore	13	47	48	43	25
Jordan	3	3	33	49	18
Total	3440	5718	8046	14 584	12 290

Source: Nursing and Midwifery Council (NMC) www.nmc-uk.org.

The impact of the movement of health workers on national health systems is felt more in developing countries, and especially so on economically disadvantaged rural communities, already having fewer professionals, operating in much weaker systems compared to those in urban areas and developed countries.[87] High turnover and attrition of health workers due to internal movement to the private sector, and externally to developed countries together with the HIV/AIDS epidemic, TB and malaria in situations where there are very few public health facilities, increase the burden. The result of this is a situation where developing country governments find themselves hard pressed to fulfill the obligation to provide universal access to basic health services.

Limited reach of public sector services with limited access by vulnerable populations including women, youth, rural communities, commercial sex workers, and others is also a real problem. Limited managerial and technical capacity to provide care at all levels of the health system and low domestic budgets to finance health care for the majority of the population, all overwhelm already overstretched staff. A consequence for those who remain employed at home is the increase in number of patients that one has to cover-resulting in frustration, stress and low morale. There is also the knock-on effect of the

[85] See UK Department of Health 2002.
[86] Pang et al. 2002. Also see General Medical Council, 2004.
[87] Commonwealth Secretariat, UNESCO, 2003.

erosion of a country's human resources capacity in terms of its ability to plan and deliver education and training for its health workforce. Paradoxically it may make sending countries more reliant on the inflow of specialist workers, particularly those countries that can afford to get these specialists working in rural areas, like South Africa. This in itself creates a new set of financial challenges of its own.

It is difficult not to see the brain drain that comes with the *migration* of health professionals in situations, as is usually the case with the health sector, where governments have invested in education of these people.[88] Thousands of nurses-the vast majority of them women-migrate each year in search of better pay and working conditions, professional development, and a better quality of life. It is estimated that 30 000 nurses and midwives educated in sub-Saharan Africa are now employed in seven OECD countries.[89] In 2000, over 500 nurses left Ghana alone for employment in industrialized countries.[90] That was more than twice the number of new graduates from nursing programs in the country that year. In Malawi, between 1999 and 2001 over 60% of the registered nurses in a single tertiary hospital (114 nurses) left for employment in other countries.[91] In 2003, a hospital in Swaziland reported that 30% of their 125 nurses were lost to work abroad[92] and between 1999 and 2001, Zimbabwe lost 32% of their registered nurses to employment in the United Kingdom.[93] The number of countries sending international nurse recruits to the UK increased from 71 in 1990 to 95 in 2001.[94]

There are obvious benefits for receiving countries, the main one being a redress to problems of staff shortages in the health sector. The UK for example achieved its 2004 target to increase the nurse workforce by 20 000 through increase in employment of overseas nurses.[95] While many of these nurses would end up in the national health service, and therefore not necessarily be covered by the GATS, the scope for some working in private facilities, particularly as independent professionals or contractual service suppliers may be there. Another benefit is often seen as the very limited chances of these health service suppliers having been gainfully employed in their home country. The situation of over work and underpay is a common phenomenon in many SSA countries.[96]

In general though, the slip into permanence is what remains a grave concern, particularly in countries of high quality and standard of life such as Canada, UK, the US and others, posing a potential permanent loss of expertise from the source country. In his analysis of recent trends in skilled labor migration to the UK, Finley demonstrates that professional workers from developing countries are relatively unlikely to leave after a few years of residence; contrasting this with the more temporary and highly mobile pattern of their developed-world counterparts.[97] An important consideration here seems to be the absence of compensatory reverse flows in many SSA countries. This situation begs the question; what can be done? Are there some ways in which a balance can be struck between these countries interests in exporting health service suppliers through participation in regimes such as mode 4? And yet still provide universal access to basic health services to their people? The following chapter offers some thought as to potential options.

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[88] WHO & World Bank 2002.
[89] WHO 2006.
[90] Ibid.
[91] Ibid.
[92] Kober & Van Damme 2006
[93] Chikanda 2005.
[94] Buchan & Sochalski 2004.
[95] Bach 2003.
[96] Zurn et al. 2002.
[97] Finley 2002.

VIII. BALANCING MODE 4 INTERESTS WITH PROVIDING UNIVERSAL ACCESS: SOME THOUGHTS FOR DEVELOPING COUNTRIES

The movement of health service suppliers continues to be a concern world over. The importance translated into this being the subject of the 2006 World Health Report. It is not desirable, and indeed impossible, to completely prevent the movement of doctors and nurses world wide, since medicine has a strong tradition of international collaboration, with doctors moving around the globe to gain further training and different clinical experiences. There is also clear merit in international exchange and diversity, as well as economic benefit coming with remittances and technology transfer. However, it is important to balance all of this with existing obligations to provide universal access to basic health services to domestic constituents.

Are there things that can be done to create a win-win situation in this predicament? Direct policy options on the part of government to shock-absorb the effects of movement of health service suppliers on the rubric of the domestic health system? In this chapter, we look at some policy options for consideration that mainstream delivery on the obligation to provide universal access to basic services, while retaining the ability of developing countries, particularly those in SSA to benefit from, and participate in, international trade in services through the presence of their natural persons supplying health services in foreign markets under the GATS.

VIII.1. THE NEED FOR COUNTRY-WIDE ENHANCEMENT OF HEALTH CARE FACILITIES

Public and private providers of services have different priorities and therefore serve communities differently. The private sector is a *for-profit* sector and has to be obligated, through *universal service obligations*, to contribute to this cause. The public sector on the other hand has the obligation of serving all citizens and therefore must often fund the service to ensure that it is available to economically disadvantaged areas and people, and not just those who can afford. Governments must invest in the public health system so that there is a decent package of health care available to people (in SSA, the immediate priority being primary health care). This would include creation of new facilities particularly in rural areas, and staffing these with well remunerated health professionals-right from doctors, to the lowest grade involved in the chain. These service providers would also have to be beefed up with regular supplies of implements and tools for use in provision of health services.

It is also worth considering an increase in the pool of those that can provide auxiliary services. Malawi introduced a category of nursing auxiliaries to support nurses with preference given to "those already employed as nursing assistants, hospital attendants and people who can demonstrate that, after their training, they will remain in the same district".[98] While these cannot substitute for professional health care staff, they can increase the level of those with semi-skills, who can all contribute to furthering the *reachability* of health services, especially in rural areas, while at the same time, allow the State to capitalize on their unlikelihood to migrate, owing to the absence of any internationally recognized qualifications.

What must be emphasized is that such auxiliary health service providers need to be trained well on the purpose for which they are being relied, with such training emphasizing the skills that will be necessary for these auxiliaries to perform the tasks entrusted to them. Examples of the areas where auxiliaries can be useful include observation of TB treatment, distribution of insecticide treated nets (ITNs) and education on how to prevent infection from HIV. One may argue that this approach relegates the fate of people living in rural areas to the periphery, but when faced with desperate

[98] Muula et al, supra.

situations, as is the case in many SSA countries; desperate (read creative) measures may come in worthwhile in salvaging the situation. In any event, it is now widely recognized that protecting a community's health requires support beyond the responsibilities of doctors, nurses and professional medical staff. Making good linkages with private sector and civil society networks of volunteer health care providers, religious organizations and community based organizations are all important inroads into extending scope of coverage for universal access to basic health services. All these various stakeholders have resources, both human and financial that they can mobilize, pull together and inject into the process of making as far and wide as possible, the reachability, accessibility and also affordability of basic health services.

One thing that comes out clearly is that enhanced health care facilities have to come out of increased budgetary allocations for the health sector. African countries have been trying to increase budgetary allocations for health either from core national sources such as taxes, or from increased resources from international financial and other institutions such as the Global Fund to fight AIDS, TB and Malaria and others.[99] However, the prospects for substantial increase from national core budgets are thin, as there are various competing interests such as education, sanitation, food security and others, leaving inadequate resources for development of health care facilities in rural areas. While it is true that the internal prioritization process may at times be wanting, it is also necessary that these governments be assisted through increased commitment particularly in the form of financial resources from the development community, to strengthen the human, structural and organizational capacity of the health sector, as well as set up new and running health facilities in these countries. In this regard, coordination with the World Health Organization for information and technical expertise on health financing and management is important.

VIII.2. THE ROLE OF POLITICAL COMMITMENT IN PROVIDING UNIVERSAL ACCESS

In Uganda's case, is reflection of what political commitment can do to improve provision of universal access to basic health services. Uganda's President has been personally involved in the fight against HIV/AIDS infection rates. Together with a wide range of partners across all sectors of society; including local Non Governmental Organizations (NGOs), various community groups, and people living with HIV/AIDS, they have become active in country-wide prevention and treatment campaigns. The President's personal involvement in raising awareness for the *Abstinence, Be faithful and Condomise* (ABC) campaigns, lends a lot of credit to the cause and attracts significant attention, speaking loud to the magnitude of the problem, and as is often said, breaking the silence. In addition, in Uganda, a creative social marketing scheme boosted condom distribution to over a million and condom use from 7% nationwide to 85% in urban areas within a decade. A self-treatment kit for sexually transmitted infections (STIs) is sold over the counter at low subsidized prices. In 1997, government also introduced same-day voluntary counseling and HIV testing services. The Government demonstrated a commitment to building health-organization and management systems, and developing a sound legal and regulatory framework in health care. Minimum health care packages were developed and access to services improved through construction and upgrading of primary health care centers. Funds channeled to primary health care aim at targeting cost-effective interventions and have been used to increase immunization coverage, distribution of ITNs and anti-malaria tablets. There has also been expanded awareness of HIV risks and increased condom use by vulnerable groups. The Government has also established HIV/AIDS coordination mechanisms at central and district levels that are reviewed quarterly by donors and civil-society organizations.

Political commitment is a driving force in many reforms; for example if government is to deliver on increasing the training capacity of institutions so that more doctors, nurses and other health service suppliers can be trained to cushion the lacuna left with the movement of some, there is need

[99] Osewe 2006.

for commitment for all related policy issues. In such a case, it would be important to keep university lecturers and other educationalists in the health sector content with their terms of employment, so that there is a constant pool of professionals that can be relied on to teach the essential courses to students. Political commitment in prioritizing budgetary allocations to teachers and professors would be important in this regard. Other essential facilities coming with trying to achieve a wider pool of health providers domestically are student accommodation facilities, bursaries, medical facilities and others. In Malawi nursing schools have a low annual intake "because of a lack of hostel accommodation, inadequate classroom space, too few tutors, insufficient teaching and learning materials and poor finance"[100] Similarly countries like Cape Verde can only accept a new intake of nurses after some years lapse, for example, as at 2004, it was every 3 years, while in Swaziland, annual output of nurses is below the migration rate.[101] With increased allocation of national budgets into these facilities, a positive contribution to provision of universal access to basic services, from the viewpoint of increasing the available pool of health professionals domestically, can be made. However, it is clear that in order for serious inroads to be built into this, serious political commitment needs to put herein.

There is also need for strong political leadership and commitment that accepts flexibility with budgetary ceilings for the health sector. It is not uncommon that owing to pressures to reduce government spending and competing priorities, many important sectors such as health have suffered, either in the form of no implements such as protective clothing, basic equipment and drugs, or having uncompetitive salaries. With such a situation, many health professionals will leave at the sight of an opportunity. 'Fiscal space' must therefore be created to make recruitment in the public sector not only possible, but attractive as well, since this is where demand is greatest and equity best served. This increase would contribute towards the attainment of a positive climate, strengthened morale and enable greater likelihood of improved structures of governance and management. At the very core of providing an effective health care system is quite simply "improved economic performance, a stable political situation and a peaceful working environment"[102], all of which come with strong political commitment to this cause.

VIII.3. THE ROLE OF PRIVATE SECTOR: THE CASE OF BOTSWANA AND KENYA

Although rich in mineral resources, Botswana currently has the highest HIV prevalence rate than any other country in the world, with nearly 40% of the adult population estimated to be HIV-positive. In May 2001, Debswana; the diamond mining joint venture, agreed to cover 90% of the cost of treating its HIV-positive employees with life-prolonging antiretroviral (ARV) drugs. As Debswana is also the country's largest private employer, it is hoped that this model will encourage other socially responsible businesses to follow suit. Such initiatives are receiving full political support from the government, which has developed a policy that would lead to free ARV treatment in public hospitals for all suffering from AIDS.[103] Together, the Bill and Melinda Gates Foundation and Merck, have committed $100 million over five years to support the government in a comprehensive and sustainable approach – using the national policy referred to above as a basis, and integrating other programs. The overall goal is to improve the national response to HIV/AIDS from prevention, to care and treatment. The Government is working with a number of other private partners such as Harvard AIDS Institute which is providing training for health care providers, McKinsey which is assisting in drug delivery, Merck which is donating ARV medicines over the five years of the program, Boehringer-Ingelheim which is donating nevirapine for preventing mother to child transmission of HIV and Pfizer which is donating Diflucan.

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[100] Muula et al. 2003.
[101] Kober & Van Damme 2006.
[102] Ibid.
[103] More information available at http://www.who.int.

Private sector can form partnerships with government towards the attainment of universal access objectives. In Kenya, the African Medical and Research Foundation (AMREF) together with the pharmaceutical company GlaxoSmithKline has successfully promoted the use of ITNs by linking it with the establishment of a local income-generating industry. In this innovative project, community groups were trained to sew and sell ITNs. An extensive health-promotion campaign sponsored by GlaxoSmithKline got sales off to a good start, and over a four-year period more than 5 200 nets were produced. Coverage in the local communities of some 75 000 people expanded from 14% to 20%. AMREF worked with local authorities, the Ministry of Health and local businesses, to launch the Employer-Based Malaria Control in Coastal and Western Regions of Kenya project. Promotional activities were successful with initial demand for nets outpacing supplies. Kenya is also modeling cost-effective methods for drug procurement. Bulk purchasing is now done through a local procurement and distribution agency-which has produced a 40% saving on annual drug expenses. Another dimension to cooperation is the regional one-which has also proved effective in some other parts of the world such as in the Eastern Caribbean, where the Drug Service representing six countries achieved a 44% average price reduction for the top 25 drugs in the region.[104]

In order to further incentify the private sector, it may be an option for those governments that can afford, to provide subsidies to the former; either through direct financial contribution, or opportunities forgone in the payment of tax, for those that are prepared, with minimum public contributions, to provide certain pre-specified health services.

In addition to the traditional participants in development cooperation, there are international private sector corporations which can be tapped in providing financing, technical assistance, and free drugs (Bill and Melinda Gates Foundation, Merck, Pfizer, etc).[105] Such technical assistance could extend to sector reforms designed to address issues of management, financing and linkages with the private sector to improve efficiency within the health sector and quality of health care. These assistance packages could also assist governments in taking on the regulation role, for example through setting up bodies that can oversee the implementation of various policies working towards universal access in the health sector. Indeed, when one looks at the *Sustainable health financing, universal coverage and social health insurance resolution adopted by the World Health Assembly in May 2005*, it is clear that the role of private providers particularly in health financing is recognized, with States being called upon to take advantage, where appropriate, of the opportunities for collaboration-albeit under strong overall government stewardship.[106]

VIII.4. THE ROLE OF ENHANCED GOVERNMENT INVOLVEMENT IN STRUCTURING MOVEMENT

While demand for health service suppliers in developed countries is presently responded to primarily through movement of skilled professionals as individuals holding contracts, it is important for governments to consider more structured means through which their relevant departments can be involved in the process. This is so because once government gets more involved, it can better tie-in issues that reflect its national development objectives-particularly those related to provision of universal access linked to the health sector. For example, government can get involved in the identification of opportunities, negotiations for contractual terms; carefully designed to include provisions that lock-in the temporary element of this movement, obtaining of requisite permits, and the return of professionals. This diligence on the part of government, and the amount of planning that would be necessary for this process, would create a more formal awareness of specific numbers of persons moving, a situation that can allow the creation, on government's part, of additional flanking policies that ensure that while some health service suppliers are abroad supplying services, there is an

[104] For more information, see Sanders et al. 2005.
[105] Ibid.
[106] WHA 58.33 On line available http://www.who.int

adequate pool available domestically. This will entail direct policy choices to train more health professionals, by making it attractive to young students to read the science subjects involved herein. (Recall discussion on the role of political commitment). Government can pursue this ambition of enhanced involvement through bilateral cooperation Agreements with various key markets specifically on health service provision**.** Cooperation particularly with the International Organization for Migration (IOM) is also important, particularly at the stages of developing government policy on temporariness, as well as managing situations where there has been a slip between temporary and other.

VIII.5. UTILIZATION OF GATS FLEXIBILITIES:

If governments choose to take the route of introducing foreign presence into the health sector, then it would be important to bear in mind that flexibilities in the GATS can be used for the attainment of national public policy objectives such as obtaining universal access to basic health services. Countries can utilize the flexible approach of the GATS to scheduling commitments, by choosing the modes and sub sectors of health services in which they can make multilateral commitments based on their own potential benefit resulting from an individual national assessment. Governments can also condition such access of foreign service suppliers to performance of certain universal service obligations. For example, **where** a country chooses to make commitments in the health sector, there is possibility to condition establishment of commercial presence (mode 3), in accordance with the flexibilities in Article XIX: 2 of the GATS, to the following regulatory options, all of which would be considered legitimate limitations within the spirit of the GATS. It is necessary though that such limitations be inscribed, either as market access or national treatment conditions (on the basis of where they fit best) directly in the concerned country' schedule of commitments-making it clear that these are the conditions that foreign service suppliers would have to fulfill in accessing the country's market:

a) minimum amounts of capital that such foreign investment must have, preferably insisting on fairly large establishments (read amounts) that can afford the extra burden of implementing universal service obligations,

b) limitations on the numbers (minimum or maximum, depending on what the country seeks to achieve: filling domestic gaps, or creating jobs for locals respectively) of foreign health professionals that can be admitted to practice in these establishments,

c) minimum numbers of locals that must be employed in these establishments,

d) provisions that such private health facilities will not benefit from government subsidies,

e) inclusion of obligations that ***all*** health service suppliers at a certain level, e.g doctors, working in foreign owned private facilities have to devote a minimum number of hours a week to work in public hospitals and clinics,

f) conditions as to having a minimum number of beds for free treatment for the needy in all foreign owned hospital facilities,

g) Requirements to offer free consultation and medicines to patients for communicable and infectious diseases,

h) obligations to offer some basic medical services in remote rural areas, (this could also be done through strategic consideration as to location in the grant of licenses to foreign owned applications; outside urban areas),

i) mandatory requirements for the training of local health professionals with a view to contributing to career development, or,

j) Setting price ceilings and monitoring the strict observance of affordability in health care.

In making such commitments, countries may want to consider the possibility of such commitments only *coming into force* (i.e become legally binding and enforceable under the WTO' dispute settlement mechanism) at a future date, when a certain level of adequacy in regulatory capacity to ensure the operation of the above policy options, vis a vis beneficiaries of the commitment, is achieved. The details of specific levels aspired to and specific timing would need to be placed in a Members schedule.

The introduction of managed and regulated foreign presence in the hospital sector, with clearly defined universal service obligations, may have some benefit from the viewpoint of additional domestic resources (foreign doctors) and foreign exchange earned, being injected into the national health system. Shortage of human and financial resources, particularly for specialized health services may be improved, while additional resources can be generated for investing in and upgrading health-care infrastructure and technology.

African and other developing countries can take advantage of existing commitments, particularly in mode 2 (consumption abroad) by improving or setting up strong *niche* health facilities domestically, which can be attractive for foreign health services *consumers.* Economic growth and the new developments in information communication and technology have created larger segments of the population with ability not only to compare their supply situation with that in other countries, but also to act accordingly, and move where renowned services are available. This means that a new and vibrant market is being created for the consumption of health services in other jurisdictions. Some countries have already made inroads into this such as South Africa for certain surgical operations, and Uganda for treatment of communicable diseases like HIV/AIDS. The amount of foreign exchange (international currency) brought by these consumers of health services can be reinvested into the setting up of medical health facilities in rural and remote parts of such countries. In this regard, the sticky issue of the non-portability of medical insurance would need to be addressed through the GATS negotiations. Such host countries would also benefit from the indirectly converging linkages such as through health tourism. There are issues that arise relating to the potential creation of a two-tier system to the disadvantage of the poor, but this is a situation that proper planning, regulation and oversight on the part of government can assist in overcoming.

VIII.6. REAPING RESULTS FROM THE GATS NEGOTIATIONS

The situation that African and other developing countries find themselves in is problematic when health service suppliers move ***permanently***. However, the temporary nature of mode 4 under the GATS can be viewed as part of the solution, creating a cyclical movement that taps on benefits of brain circulation as opposed to drain.[107] The way in which mode 4 is structured can assist in creating enhanced skills, credentials, management techniques got while working in developed countries, and a greater potential for technology transfer and brain circulation resulting from a more networked global economy. On return home from their temporary period abroad, these health service suppliers are a valuable resource to their country' health system-bringing with them new and beneficial skills. The emergence of transnational communities that link the diaspora to home communities, stimulating investment and entrepreneurship is also important. Amounts of money sent back home in the form of

[107] See Khadria 2002, Saxenian 2002, Bach 2003. Also see GATS Article I, and the Annex on the Movement of natural persons for details of the coverage of mode 4 under the GATS.

remittances can also increase private resources, which can then be used for access to medical care and investments. It is possibly for some of these reasons that developing countries are pursuing an ambitious agenda in the Doha Round's mode 4 negotiations.[108]

There is also untapped scope for accessing mutual recognition Agreements (MRAs)-to go over the hurdle that many times makes it difficult for developing country service suppliers to access markets in Europe, North America and other key markets. MRAs are typically bilateral in nature, a fact recognized even in the GATS, which in Article VII only calls for an obligation to notify other Members of the intent to enter into negotiations aimed at establishing an MRA. The provision also requires affording opportunity to those interested to enter into such negotiations. Some examples of MRAs include the Australia-China arrangement on higher education qualifications recognition. It is aimed at facilitating recognition of higher academic degrees by assisting students in pursuing further academic studies in each other's countries. Ministries in participating countries are required to designate bodies that can furnish this information, and make concrete recommendations in line with regulations and practices. Another example is the UK-South Africa Memorandum of Understanding on reciprocal educational exchange of health care concepts and personnel-which, although not strictly an MRA, aims at mutual agreement on the recruitment of health personnel in England, to exchange information on professional rules and regulations, workforce planning and development, and to facilitate mutual access to universities and schools for the training of health professionals. In this regard, developing countries could use the GATS negotiations to raise the profile of the need for a more detailed discussion on how to solve the non recognition of qualifications problem-possibly under the auspices of the working party on domestic regulation. In addition, developing countries should make a concerted effort to join MRA negotiations when such notifications are received by the WTO.

VIII.7. THE MUST-HAVE PARALLEL POLICIES

While countries actively pursue enhanced mode 4 commitments, they would have to, in tandem, set up domestic policies that contribute to ensuring return of health service suppliers, such that they can tap on the benefit of temporariness envisaged under mode 4. Such policies would be aimed at creating packages that assist in and encourage reintegration of health service suppliers into their home countries upon return. These would include social and regulatory incentives such as in Argentina's case, where the National Commission for the Return of Argentineans Living Abroad was created in 1994, providing incentives such as payment of moving and establishment costs, and family travel costs.

There is also the Return and Reintegration of Qualified African Nationals (RQAN) program, which '*aims to develop a country's economy by seeking persons who are highly trained and qualified either to return or find positions in each country that will benefit from that persons' training*. The program is used by 11 African countries including Angola, Cape Verde, Ethiopia, Ghana, Guinea Bissau, Kenya, Mozambique, Sierra Leone, Uganda, Zambia and Zimbabwe. All the countries in SSA, except South Africa, are considered non-target, and can also be assisted on a country basis.

The program operates through identifying priority employment sectors to be strengthened, identifying job vacancies in cooperation with various private and State enterprises and government administration, as well as identifying, screening and selecting (recruiting) appropriate candidates on the basis of set guidelines. The program also conducts training of government counterparts in main target countries on recruitment, placement, follow up activities, and reintegration processes.[109] The persons sought must be African nationals and skilled in a trade considered priority to the receiving country. Some of the services that are offered by the program include the payment of return airfares, shipment of personal effects, financing of some professional equipment expenses, and some settling-in

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[108] IDRC, Privatization, Liberalization and GATS, http://www.idrc.ca/en/ev-67858-201-1-DO_TOPIC.html.
[109] See www.iom.int.

expenses. There is also a low interest loan available to facilitate business start-ups. Between 1983 and 1999, the program is reported to have achieved an average return rate of around 100 per year.

Some developing countries with more resources compared to those in SSA such as Korea have attempted to recruit older professionals and academics using internationally competitive salaries, enhanced working conditions, help with child care and housing, and through the use of visiting professor schemes for those unsure about a permanent return. According to a United Nations Development Program (UNDP) 2001 report, Korea was achieving a return rate of 60% in the 1980s.

Countries would also have to set up some other flanking policies at the domestic level that ensure that *potential mode 4 participants* contribute to the governments objective of achieving universal access to basic health services. Government's strongest policy interventions are those within its own jurisdiction. The point in linking these domestic health service suppliers to the mode 4 debate, inspite of the fact that they are still within domestic jurisdiction, is that in the absence of these policies, such service suppliers would find it easier to get magneted to contracts abroad, or in the alternative, that these policies make the domestic situation attractive, hence reducing the potential for these health services suppliers to seek foreign contracts, or accept them when got. The idea would be for government to create a conducive environment at home such that health service suppliers are enticed to stay, or rules governing the practice in the medical profession that ensure State benefit, atleast in the immediate period after training. Some of the options that countries can consider include the following:

a. Creating obligations on health service suppliers who have benefited from government subsidies in the course of their training to provide health services in the public sector for a certain number of years, before branching off into private practice, or taking on contracts abroad. In the case of Thailand, when the country was faced with large outflows of domestic health service suppliers, it opted for requiring students to sign contracts with public universities, wherein they committed themselves to serving the public for three years after graduation. At least two thirds of the contracted new graduates were dispatched to hospitals in rural districts. In this time, it is noted that the health facilities in rural districts improved a great deal with the situation in 2000 being that these graduates covered more than 90% of all rural districts-which were all equipped with modern facilities and trained staff.[110]

b. Direct government policy aimed at increasing supply, including through increased rural recruitment, and the potential for home town placement of health service suppliers. Placing people in their original home areas, which many times is out of the urban cities, is often attractive. This would also build inroads into the issue of internal brain drain. It would be important that such persons recruited in rural areas get additional benefits such as hardship allowances, housing, transportation, education grants for their children as well as other dependency allowances-to make living somewhat more comfortable.

c. In country speciality training has also been cited as an incentive-wherein doctors gain specialized skills from within their countries, and accreditation for the same. This would encourage some health professionals to stay at home as they would not only have access to skills that were previously only available abroad, but also accreditation and recognition for the same. The speciality of these skills would also bring attraction, as arguably they would not be common place domestically. This, coupled with hardship and relocation allowances for those in rural areas, have had some level of success in some countries. In addition, other policies that offer recognition, regular

[110] See Suwat Wibulpolprasert, International trade and migration of health care workers: Thailand's experience.

promotions with the attendant benefits coming therewith, particularly for those that work in rural areas, could also be useful.

d. Provision of low interest loans to nationals for setting up health facilities in rural areas.

e. Financial incentives such as competitive salaries for health workers, bonuses, pension, medical insurance, allowances, fellowships, loans and scholarships are also effective.

However, wage increments are not something that comes easy in SSA country budgets, many of which rely heavily on donor funding. In any event, any potential increments could possibly still compare weak to those wages that health professionals can get in developed countries. Even doubling local salaries has not reduced migration, since the income gap remains considerably large between developed and developing countries.[111] As such, it is important that governments consider some non-monetary incentives such as the following:

a) strengthening work autonomy,

b) encouraging career development, providing opportunities for training abroad**,**

c) upgrading facilities with practical tools and implements to carry out day to day work, including such basic things as gloves, cotton wool, surgical tools,

d) adapting working time and shift work (for nurses),

e) reducing violence in the workplace, and,

f) open leadership.

It has been reported that realignment of the career structure and promotion based on ability was able to reduce the number of Zimbabwe health professionals leaving the country in the 1990s.[112] Other non-monetary incentives that have had some level of success include outside-sector benefits. In the Caribbean for example, some States gave health workers access to loans for housing or cars, at exceptional rates or without financial deposits. In Ghana, health workers were entitled to better day care for their children![113]

There is a role for receiving countries to play. With the limited budgets of SSA countries, there is a limit to the extent to which they can present attractive packages. In this regard, binding codes of practice for recruitment become important, wherein countries restrain themselves from recruiting health service suppliers from this region. The issues surrounding ensuring return hinge on cooperation between the sending and receiving countries. These measures would only come into effect if governments are involved in the process-through departments of labor and others relevant thereto. Some of these include:

a) Agreements with receiving countries that a substantial amount of the wages are paid in the service provider's account in the sending country,

b) that there be mandatory monetary deposits, prior to exit,

c) attractive investment packages on return such as low interest loans and tax holidays.

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[111] VuJicic et al. 2004.
[112] Ibid.
[113] Ibid.

There is also scope for use of cyclical training programs that give health professionals a chance to improve their skills abroad, make some money and go back home. An example is the Ghana–Netherlands Healthcare Project, managed by the IOM, whose objectives are to transfer knowledge, skills and experiences through short-term assignments and projects to facilitate short practical internships for Ghanaian medical residents and specialists in the Netherlands and to develop a centre for the maintenance of medical equipment in Ghana.

VIII.8. THE ROLE OF REGULATION

There is no way any of the above-mentioned policy interventions can work in the absence of proper, well designed regulation that ties the need to fulfill universal access to basic health services into directly and indirectly concerned government policy. None of the foreseen benefits of mode 4 in terms of linkages with building inroads into meeting universal access obligations, can materialize in the absence of a sound regulatory framework of the health sector. Such regulation would need to focus and insist on enforcing the temporary nature of this movement in various Agreements to which a government is party, as well as oversee the day to day running of foreign and domestic owned private health facilities-particularly on how they are meeting universal service obligations entrenched in their licenses of operation. Such regulation includes, but is not limited to laws, rules, the set up of independent regulatory institutions, and the training of people in skills to run them. In this regard, the role of exchange programs in learning what works best, and what it takes to adapt best case scenarios to local situations is valuable. It is important for governments to strengthen the role of their ministries of health in collaborating with independent regulatory bodies, with a view to ensuring that health service operators are brought in line with whatever universal service obligations govern their licenses. There is no way around inter-ministerial coordination if any of this is to work: among the health ministry as the main providers of health services, trade ministry as negotiators of trade Agreements, economic planning as the custodians of national development plans, education as the people behind syllabi and finance as the purse holders, as well as all other relevant line ministries.

There is nothing in the GATS that estoppes a country from regulating in the public interest. In the preamble to the GATS, Members' Right to regulate and introduce new regulations in order to meet national policy objectives is held sacrosanct. As such, universal service obligations, either as conditions to market access in the GATS, granting of licenses at the domestic level, or indeed in any other form in the pursuit of national development strategies, including the provision of universal access to basic health services, are very much within the ambit of acceptable.

IX. CONCLUSION

Governments have a central role to play in ensuring universal access to basic health services. There is no choice, but implementation. In fulfilling this obligation, governments can either provide universal access to health services through being the sole providers, through carefully thought and designed universal service obligations for private sector, or through partnering with private providers, with a heightened oversight and regulatory role. **If** governments choose to introduce foreign presence into the health sector, they can use the GATS flexibilities to structure their commitments in such a way that the beneficiaries thereto meet certain universal service obligations. Governments can also consider certain policies that entice health service suppliers to stay at home, or for those that go, to return. Whatever policy options governments choose, the fundamental responsibility to deliver remains with them. The pursuit of mode 4 commitments and utilization thereof, need not be at logger heads with provision of universal access to basic services. Indeed, as this paper has argued, enhanced market access commitments on mode 4, emphasizing its temporariness, can be seen as part of the solution.

None of these options is presented as workable in isolation. As such, there is unlimited scope for a *mélange of options,* for each country to see what suits it best. Indeed, for any of these to work, there is a heightened role of regulation that must be in place. As can be seen, each of the proposals can be expanded and detailed, as they all present some challenges particularly of design and implementation. This Research Paper does not seek to address the challenges, but rather to make a constructive contribution to the process of thought that needs to go into shock absorbing the effects of the movement of natural persons to the provision of health services. Indeed, a major objective of the paper has been to demystify the negative link that is often made with mode 4 and health services, and rather create the start of discourse towards a positive agenda on mode 4 that can be viewed as harnessing and contributory to various issues, including universal access to basic services, and not contradictory, or defeating in purpose.

X. ANNEXES

ANNEX A: NUMBERS OF WTO MEMBERS WITH COMMITMENTS ON INDIVIDUAL HEALTH SERVICES, JUNE 2003

		Medical and Dental Services	Midwives, Nurses, etc.	Hospital Services	Other Human Health Services
TOTAL		62	34	52	22
MARKET ACCESS					
Mode 1	Full	21 (-2)	8 (-1)	18	11
	Partial	12	6	1	1
	Unbound	29	20	35	10
Mode 2	Full	35 (-3)	12 (-1)	44	15
	Partial	24	21	5	5
	Unbound	3	1	3	2
Mode 3	Full	29 (-8)	7 (-2)	18 (-8)	12 (-5)
	Partial	26	25	31	9
	Unbound	7	2	3	1
Mode 4	Full	0	0	0	0
	Partial	56	32	48	21
	Unbound	6	2	4	1
NATIONAL TREATMENT					
Mode 1	Full	24	9	21	12
	Partial	10	6	1	1
	Unbound	28	19	30	9
Mode 2	Full	34	12	44	15
	Partial	23	21	5	5
	Unbound	5	1	3	2
Mode 3	Full	19	10	33 (-24)	11 (-4)
	Partial	37	22	15	9
	Unbound	6	2	4	2
Mode 4	Full	3	1	3 (-1)	1
	Partial	54	31	44	19
	Unbound	5	2	5	2

Note: EC Member States are counted individually. Reduced number of full commitments if horizontal limitations, which apply to all sectors contained in the individual country schedules, are taken into account.

Partial commitments on market access include commitments that carry any of the six limitations specified in Article XVI: 2 of GATS as well as commitments subject to limitations in sectoral coverage (e.g. exclusions of small hospitals or public sector entities) or geographical coverage within the Member's territory, and any other measures scheduled in the relevant column (including domestic regulatory measures for which Article VI might have provided legal cover). Similarly, partial commitments recorded under national treatment may include cases of "over-scheduling" or misinterpretations.

ANNEX B: SUMMARY OF SECTORS, AND SUB SECTORS IN THE LDC REQUEST

Business visitors: Professional services; Legal services, accounting, auditing and book keeping, architectural services, engineering services, integrated engineering services, urban planning and landscape architectural services, medical and dental services, services provided by midwives, nurses, physiotherapists, and Para-medical personnel.
Computer related services; Consultancy services related to the installation of computer hardware, software implementation services, data base services.
Research and development services; R&D services in natural services, R&D services on social sciences and humanities, interdisciplinary R&D services
Real estate services: Involving own or leased property, on a fee or contract basis
Other business services: Advertising services, market research and public opinion polling services, management consulting services, technical testing and analysis services, services incidental to agriculture, hunting and forestry, services incidental to fishing, services incidental to mining, services incidental to manufacturing, services incidental to energy distribution, related to scientific and technical consulting , maintenance and repair equipment, photographic services, packaging services, printing, publishing, convention services
Communication services: Postal services Courier services, telecommunication services, and audio-visual services
Construction and related engineering services, environmental services,
Education services
Financial services: All insurance and insurance-related services, banking and other financial services
Health related social services
Tourism and travel related services: Hotels and restaurants, including catering, travel agencies and tour operators services, and tourist guides.
Recreational, Cultural and sporting services: Entertainment services, News agency services, libraries, archives, museums, and other cultural services, sporting and other recreational services.
Transport services: Maritime transport services and internal waterways transport.

XI. REFERENCES

- Adlung, R. & Carzaniga, A. (2002). *Health Services Under the General Agreement on Trade in Services*, Bulletin of the World Health Organization.
- Adlung, R., *The GATS Negotiations: Implications for Health and Social Services*, Intereconomics, 5: 147-155, 2003.
- Adlung, R, *WTO and Trade in Health and Social services*, GASPP Seminar, Dubrovnik, 26-28 September 2002.
- Adlung, R, *Health services in a globalizing world*, eurohealth, Vol.8, No.3, Summer 2002.
- Adams, O. & Kinnon, C. (1998), *"A Public Health Perspective"*, *International Trade in Health Services: A Development Perspective*, Geneva.
- Adversario, S. (2003), *"Nurses' exodus making health system sick"*, Interpress Service, http://www.ipsnews.net.
- Alubo, S. (1990), *Debt crisis, health and health services in Africa*, *Social Science & Medicine*.
- Awases, M. et al. (2004), *Migration of health professionals in six countries*, WHO Regional Office for Africa, Brazzaville (2004).
- Bach, S. (2003), *International Migration of health workers: Labour and social issues*, ILO, Geneva.
- Ball, R. (1990), *The process of international contract labour migration from the Philippines: The case of Filipino nurses*, Department of Geography, University of Sydney, Sydney, Australia.
- Blouin, C, Drager, N, Smith R, *International trade in health services and the GATS, current issues and debates*, The World Bank, 2006.
- Buchan J. et al. (2004), *International nurse mobility: Trends and policy implications*, WHO, ICN and RCN, Geneva (2004).
- Buchan, J. & Sochalski, J. (2004), *The migration of nurses: trends and policies*, Bulletin of World Health Organization 82 (8), WHO, Geneva, Switzerland.
- Bundred, P. & Levitt, C. (2000), *Medical migration: Who are the real losers?* in The Lancet, 2000, Vol. 356, pp. 245-246.
- Chanda, R., *Trade in health services*, in Bulletin of the World Health Organization, Vol. 80, No. 2.
- Chikanda, A. (2005), *Medical Leave: The Exodus of Health professionals from Zimbabwe*, Southern African Migration Project, University of Toronto.
- Commonwealth Secretariat. (2004). *Commonwealth code of practice for the international recruitment of health workers.* Paragraph 11, 2003.

- Connell, J. et al. (2007), *Sub-Saharan Africa: Beyond the Health Worker Migration Crisis?* Social Science & Medicine, Volume 64, Issue 9, May 2007, p. 1876-91.
- Connell J. & Stilwell, B. (2006), *Merchants of medical care: Recruiting agencies in the global health care chain*. In: C. Kuptsch, Editor, Merchants of labour, ILO, Geneva.
- David P. et al. (1999), *How the World Trade Organization is shaping domestic policies in health care,* The Lancet 354 (27 November).
- Deininger, K. & Mpuga, P. (2004), *Economic and Welfare Effects of the Abolition of Health User Fees: Evidence from Uganda*, World Bank Policy Research Working Paper 3276.
- Delorey, A. (2006), *The feminization of health care migration*, Canadian Women's Health Network Magazine 8, (3/4).
- Department of Health (2002), *Projected supply, demand, and shortages of registered nurses*: 2000-2020 .http://bhpr.hrsa.gov/healthworkforce/rnproject/report.htm
- Diamond, D. (2002), *"One nation, overseas"*, http://www.wired.com/wired/archive/10.06/philippines-pr.html
- Drager, N., & Vieira, C. (Eds.), (2002). *Trade in health services: global, regional and country perspectives*. Washington, DC: PAHO.
- Drager, N, Mc Clintock E, & Micheal Moffit, *Negotiating health development: A guide for practitioners*, WHO 2000.
- Dumont, J., & Meyer, J. (2004). *The international mobility of health professionals: An evaluation and analysis based on the case of South Africa.* In OECD (Ed.), Trends in international migration. Paris: OECD.
- Dussault, G. & Franceschini, M. (2006), *Not enough there, too many here: Understanding geographical imbalances in the distribution of the health workforce*, Human Resources for Health 4 (12).
- Fan, S. & Rao, N. (2003), *Public spending in developing countries: trends, determination, and impact*, International Food Policy Research Institute, Washington, U.S.A.
- Findlay, A. (2002), *From brain exchange to brain gain: Policy implications for the UK of recent trends in skilled migration from developing countries*, International Migration Papers No. 43 (Geneva, ILO).
- General Medical Council. (2004). *Personal communication*.
- Geray, A. M. et al. (1993), *Nursing in the European Labour Market: an Economic Perspective*, in C.E.M. Normand and P. Vaughan Editors, *Europe Without Frontiers*. John Wiley and Sons Ltd.
- Go, S. (2003), *Recent trends in migration movements and policies: The movement of Filipino professionals and managers*, in OECD: Migration and the labour market in Asia, Paris.
- Hagopian, A. et al. (2005), *The flight of physicians from West Africa: Views of African physicians and implications for policy*, Social Science & Medicine 61.
- Khadria, B. (2002), *Skilled labour migration from developing countries*: Study of India,

- International Migration Papers No. 49 (Geneva, ILO).
- Kingma, M. (2001): *Nursing migration: Global treasure hunt or disaster in the making?* in Nursing Inquiry, 2001, Vol. 8, No. 4, pp. 205-212.
- Kingma, M. (2006), *Nurses on the move*, Cornell University Press, Migration and the Global Health Care Economy, Ithaca.
- Kober, K. & Van Damme, W. (2006), *Public sector nurses in Swaziland: can the downturn be reversed Human Resources for Health* (31 May).
- Lee, K. & Koivusalo, M. (2005), *Trade and Health: Is the Health Community Ready for Action?,* PLOS Medicine, http://medicine.plosjournals.org
- Lee, K, Buse K and Fustukian S, *Health policy in a globalizing world,* Cambridge university press, 2002.
- Lethbridge, J. (2002), *Social dialogue in health services: Case studies in Brazil, Canada, Chile,* United Kingdom, Sectoral Activities Working Paper No. 189, ILO, Geneva.
- Loff, B. & Gruskin, S. (2000), *Getting Serious about the Right to Health,* The Lancet, Volume 356, Issue 9239, 21 October, P. 1435.
- Luck, M. et al. (2000), *At the other end of the brain-drain: African nurses living in Lisbon,* Studies in Health Service Organization and Policy 16 (2000), pp. 157–169.
- Mackintosh, M. & Tibandebage, P. (2002), *Inclusion by design? Rethinking health care market regulation in the Tanzanian context. J Dev Stud* 39: 1-17.
- Martineau, T. et al. (2002), Briefing note on international migration of health professionals: *Leveling the playing field for developing country* health systems. http://www.liv.ac.uk/lstm/hsrhome.html.
- Mashayekhi, M. & Tuerk, E. (2003), *The WTO services Negotiations: Some Strategic Considerations,* South Centre, Geneva.
- Mejia, A. et al. (1979) *Physician and nurse migration: Analysis and policy implications*, WHO, Geneva.
- Mullan, F. (2005) *The metrics of the physician brain drain, New England Journal of Medicine* 353 (17), pp. 1810–1818.
- Muula, A. et al. (2003), *The ethics of developed nations recruiting nurses from developing countries: The case of Malawi*, Nursing Ethics 10.
- Muula A. & Maseko, F. (2006) *How are health professionals earning their living in Malawi?* BMC Health Services Research 6 (97).
- Nielson, Julia and Oliver Cattaneo (2004). *"Current regimes for the temporary movement of service providers: Case studies of Australia and the United States."* In Mattoo and Carzinga "Moving people to deliver services". Oxford University Press and World Bank, Washington, D.C. (2004).
- OECD (2003), *Trends in international migration*: Annual report 2002 edition, Paris.

- Ojo, K. (1990), *International migration of health manpower in sub-Saharan Africa*, Social Science & Medicine 31.
- Osewe, P. (2006), *Strengthening the Role of the Private Sector in Expanding Health Coverage in Africa*, World Bank.
- Palmer, D. (2006), *Tackling Malawi's human resources crisis, Reproductive Health Matters* 14(27).
- Pang, T. et al. (2002), *Brain drain and health professionals*, *British Medical Journal* 324(7336).
- Pollock, A. M. & Price, D. (2000), *Rewriting the regulations: How the World Trade Organization could accelerate privatization in health-care systems*, The Lancet 356 (9 December).
- Pond, B. & McPake, B. (2006), *The health migration crisis: The role of four Organization for Economic Cooperation and Development countries*, Lancet 367.
- Rupa, C. (2001), *Trade in Health Services*, Working paper No. 70., Indian Council for Research on International Economic Relations.
- Sanders, D. M. et al. (2005), *Confronting Africa's health crisis: more of the same will not be enough*, IFPMA Clinical Trials Portal, http://www.bmj.com/cgi/content/full/331/7519/755 http://www.bmj.com/cgi/content/full/331/7519/755
- Saxenian, A. (2002), *Brain circulation: How high-skill immigration makes everyone better off*, in Brookings Review, Vol. 20, No. 1, pp. 28-32.
- Sinclair, S & Grieshaber-Otto, J. (2002), *Facing the facts: a guide to the GATS debate*, CCPA, Ganada.
- Sinclair, S. (2000), *GATS: How the World Trade Organisation's New 'Services' Negotiations Threaten Democracy*, Canadian Centre for Policy Alternatives, Ottawa.
- Sison, M. (2003), *Health system suffers brain drain*, http://www.ipsnews.net/migration/stories/braindrain.html.
- Stilwell, B. et al. (2004), *Developing evidence-based ethical policies on the migration of health workers: Conceptual and practical challenges* (Geneva, WHO).
- Sumanta Chaudhuri, Aaditya Matto, Richard Self, *Moving people to deliver services: How can the WTO help?* World Bank Policy Research Working Paper 3238, March 2004.
- UNCTAD (1997), *International Trade in health Services: Difficulties and Opportunities for Developing Countries*, background note.
- Venning, P. et al. (2000), *Randomized controlled trial comparing cost effectiveness of general practitioners and nurse practitioners in primary care*, British Medical Journal 320 (7241).
- Volqvartz, J. (2005), *The brain drain*, The Guardian 11 March.
- Vujicic, M. et al. (2004), *The role of wages in the migration of health care professionals from developing countries*, Human Resources for Health 2, (3).
- WHA 58.33 *Sustainable health financing, universal coverage and social health insurance*.

- Wibulpolprasert, S. (1999), *Inequitable distribution of doctors: Can it be solved?* in Human Resources for Health Development Journal, Vol. 3, No. 1, pp. 2-22.
- Wickramasekara, P. (2003). *Policy responses to skilled migration: Retention, return and circulation.* Perspectives on Labour Migration No. 5E, ILO, Geneva.
- Winkelmann-Gleed, A. (2006), *Migrant nurses. Motivation, integration and contribution*, Radcliffe, Oxford.
- Wiskow, C. (2005), *Management of international health worker migration: Instruments on ethical recruitment and other policy options.* Unpublished Mimeo, Geneva.
- Whitehead, M., et al. (2001), *Equity and health sector reforms: can low-income countries escape the medical poverty trap? Lancet* 358: 833-6.
- WHO (2002), *Trade in Health Services: Global, Regional and Country Perspectives*, Washington DC: Pan American Health Organization, Program on Public Policy and Health, Division of Health and Human Development.
- WHO & World Bank (2002), *Building strategic partnerships in education and health in Africa*: Report on the Addis-Ababa Consultative meeting, www.who.afro.who.int.
- WHO (2003), *International nurse mobility: Trends and policy implications*, International Council of Churches, and Royal College of Nursing, Geneva.
- WHO (2006), *The world health report 2006 - working together for health*, WHO, Geneva.
- WTO (2001), *Market Access: Unfinished Business*, Special Studies 6, Geneva.
- Xaba, J. & Phillips, G. (2001), *Understanding nurse recruitment*: Final report (Pretoria, DENOSA).
- Zewdie, D. (2005), *The HIV/AIDS Epidemic in Africa: Implications for Development*, United Nations Commission on Population and Development, New York.