

Foreign direct investment and trade in health services: A review of the literature

Richard D Smith*

Health Economics, Law and Ethics Group, School of Medicine, Health Policy and Practice, University of East Anglia, Norwich NR4 7TJ, UK

Abstract

Globalization is a key challenge facing health policy-makers. A significant aspect of this is direct trade in health services, a result of the rise of transnational corporations, challenges in health care financing, porous borders and improved technology creating the scope for increased 'foreign direct investment' (FDI) in health care. This has gathered momentum with the General Agreement on Trade in Services (GATS), which aims to further liberalize trade in services, and within which FDI has been noted as perhaps the most critical area for trade negotiation.

Given the rapid development of this area, there are little empirical data. This paper therefore seeks to provide the first comprehensive and systematic review of evidence concerning FDI and health services. This process included electronic bibliographic database searches, website searches and correspondence with experts in the area of trade in health services, from which 76 papers, books and reports were reviewed.

Perhaps due to the rapid developments in this area, most of the literature is speculative, polarized between those arguing for the benefits of liberalization and those arguing against. However, there seem to be three issues which emerge as of most importance: (i) the extent to which a national health system is commercialized per se is of more significance than whether investment in it is foreign or domestic; (ii) the national regulatory environment and its 'strength' will significantly determine the economic and health impact of FDI, the effectiveness of safeguard measures, and the stability of GATS commitments; and (iii) any negotiations will depend upon parties having a common understanding of what is being negotiated, and the interpretation of key definitions is thus critical. Each of these issues is explored in some depth, with the overall conclusion that countries should take a step back and first think through the risks and benefits of *commercialization* of their health sector, rather than being sidetracked in to considering the level of *foreign* investment.

© 2004 Elsevier Ltd. All rights reserved.

Keywords: GATS; Trade in health services; Foreign investment

Introduction

Globalization is a key challenge facing health policy-makers (Yach & Bettcher, 1998a,b; Woodward, 2001). Whilst effects on health from, for example, cross-border flows of infectious disease are important aspects of globalization, a significant challenge concerns the globalization of the health sector itself: direct trade in health-related goods, services and people (patients and professionals).

The health sector has been relatively unaffected by globalization directly, as it remains a predominantly

service-oriented sector. Most trade liberalization concerns the movement of 'goods', since these can be 'stored' and therefore transported (Woodward, 2001). However, while services (such as banking, education and telecommunications) account for only around 20% of global trade (on a Balance of Payments basis) this sector is the fastest growing.¹ Much of this growth has resulted from changes in technology, making, for example,

¹Foreign direct investment flows growing 20-fold in the last 20 years, to a world total of around US\$1.27 trillion (UNCTAD, 2001). Note, however, that movement of providers and commercial presence are not generally included in these statistics, so the overall level is likely far higher.

*Tel.: +44-0-1603-593617; fax: +44-0-1603-593604.

E-mail address: Richard.Smith@uea.ac.uk (R.D. Smith).

e-commerce and tele-medicine a technical possibility, and easier travel and border restrictions making movement of patients and professionals feasible.

Improved technology and porous borders has also facilitated the rise of transnational corporations (TNCs), making the ownership and management of production facilities more fluid (Adlung & Carzaniga, 2001). However, it is not clear what impact such 'foreign direct investment' (FDI) may have in the health sector. This is important given developments in international legislation as a result of the General Agreement on Trade in Services (GATS), which arose from the World Trade Organization (WTO) negotiations of 1994.²

GATS is a system of 'binding' international trade rules designed to promote economic development through progressive trade liberalization (Bettcher, Yach, & Guindon, 2000).³ It specifies four 'modes of supply': (i) 'cross-border supply', where the service, but neither producer or consumer, crosses a border (e.g. telemedicine); (ii) 'consumption abroad', where the consumer crosses a border to obtain a service (e.g. medical 'tourism'); (iii) 'commercial presence', where companies make FDI in the service sector of another economy (e.g. a foreign company investing in a domestic hospital); and (iv) 'temporary movement of service providers', where skilled workers move to other countries to work for a limited period. Of these, mode 3 (commercial presence) is arguably the most critical (Sinclair & Grieshaber-Otto, 2002). For example, FDI in building hospital facilities will have considerable impact on basic health infrastructure, and is likely to challenge the public-health nature of many health systems.⁴ Mode 3 also underpins much of the activity associated with other 'modes' (for example, whether foreign patients are attracted, or outward migration of health professionals is forestalled), and the potential for future growth through trade is likely to be greatest through mode 3.

Increased FDI will present opportunities and challenges, risks and benefits, to developed and developing countries, to those exporting and those importing

investment. However, given the 'binding' nature of GATS, there is concern that their adoption threatens to outpace the ability of governments to adjust to them, let alone guide them (Adlung, 2002; Price & Pollock, 1999). It is therefore crucial that there is an understanding of the likely impact and issues associated with FDI (Mashayekhi & Julsaint, 2002).

This paper thus seeks to assess the major issues surrounding FDI in health services through a systematic review of the literature.⁵ Note that the perspective taken is one of the protection and promotion of *health*, most especially of low- and middle-income countries, and is therefore concerned with the 'import' rather than the 'export' of FDI.⁶ Following this introduction, the paper provides a brief background to both FDI and GATS, before moving on to outline the methodology used to search for, and review, the literature in this area. The following section then presents a discussion of key issues emerging from this literature, and the final section concludes with key messages.

Background to FDI and GATS

This section provides a brief overview of the characteristics, risks and benefits of FDI, and an overview of the core features of GATS with respect to FDI.

FDI

The financing of health services can come from sources within a country (tax or insurance for example), or from without. The latter can be further sub-divided into commercial finance, official aid or non-governmental finance. Commercial financial flows may further be divided into portfolio/equity investments, commercial loans or FDI. It is this last category that is of interest in this paper.⁷

²Further information on GATS is available at: <http://gats-info.eu.int/>

³This is based on traditional economic arguments relating to 'comparative advantage' (production being centred where cost is lowest), improved process quality and innovation (e.g. technology transfer), ensuring national resilience to exogenous shocks, ensuring consumers continued product availability and reducing the economic power of individual economic operators. These are, of course, contentious claims.

⁴It may also be the case that pharmaceutical/medical device companies, although their product is not covered by GATS because it is not a service, may use FDI in, for example, hospital development, as a strategic means to obtain greater market share for their actual products. However, this paper is concerned with direct FDI, and such a strategic use of FDI is not considered in any detail here.

⁵Note that this paper is concerned only with the direct impact of trade in *health services*. It is not concerned with the wider impact on health of other elements of trade in services, or vice versa, nor with trade in health service inputs, such as pharmaceutical retailing or medical devices.

⁶Of course this is a rather 'artificial' dichotomy as there will be trade-offs being made between imports and exports, and the manner in which a country opens its health sector to imported FDI will be linked to what is going on with its health services (FDI) export policy. However, low- and middle-income countries may reasonably be considered to be more likely to be considering inward FDI as a means of improving their domestic health care system, than looking at outward FDI of health services (which may change over time).

⁷Note that there is also a substantial element of FDI in developing countries by non-profit, charitable and religious organizations. However, this paper is primarily interested in the

Definition and characteristics of FDI

FDI may be defined as an investment involving a long-term relationship, and reflecting a lasting interest and control, of a firm or individual from one country in another. Forms of FDI include equity capital, reinvestment of earnings from the ‘host’ country, and provision of long- and short-term intra-company loans. TNCs often engage in this form of investment, through the ‘parent-affiliate’ model of control and ownership, where the ‘domestic’ parent company controls the assets of the ‘foreign’ affiliate firm, usually through equity capital stock ownership, but which may or may not directly manage it (IMF, 1993). The most important characteristic of FDI, which distinguishes it from portfolio investment, is that it is undertaken with the intention of *exercising control* (total, majority or ‘significant’ share ownership—the standard threshold being 10%) over the enterprise being invested in (Woodward, 2001).

Compared with public sector funding, such as loans and grants, FDI is becoming increasingly important in the global economy (Woodward, 2001). For example, FDI from the developed to the developing world grew from US\$36bn in 1992 to US\$155bn in 1999; a level more than three-times that of official development aid (HMSO, 2000). Within this there has been a steady shift in FDI from goods to services, and toward the end of the 1990s FDI in services accounted for over half of all FDI (UNCTAD, 1997).

Most foreign investors, of course, find it risky to invest in *developing* nations, where only a few can afford private treatment and/or insurance. It is therefore more common to see FDI through joint ventures with local partners to ensure access to qualified personnel and a better understanding of local culture and characteristics.⁸ As well as this commercial risk, there are also political and foreign exchange risks, which are generally interrelated. GATS, as described below, seeks to reduce these risks and thus increase FDI activity. As experience grows, and more health services are ‘privatized’, one might therefore expect to see foreign investment grow as companies seek profit increases away from the traditional ‘saturated’ developed economies (Bajpai & Sachs, 2000).

Potential risks and benefits of FDI

Although companies become involved in FDI for profit reasons (often directly, but also indirectly, for

(footnote continued)

impact of FDI by private, for-profit, organizations, as these are the organizations that GATS, and the liberalization agenda more broadly, aims to stimulate (i.e. *commercial* presence).

⁸There are also constraints on FDI, especially in health, in terms of the limited commercial market and that costs are linked more to location than supplier.

example through ensuring access to resources, providing support services to other investments and/or strategic political objectives), why might countries wish to invite FDI in health? For many, the attraction is debt-free investment;⁹ the benefit being especially great where investment leads to gains in basic, as well as sector specific, infrastructure (e.g. roads and telecommunications) (ODI, 1997). Broadly, it is hoped that such investment will bring additional resources and expertise to improve the range, quality and efficiency of services offered, although this depends on the form of regulation (Chanda, 2001; Zhang & Felmingham, 2002). For example, public sector resources could, in principle, be released to improve health care for the poor if the wealthy pay for care from these new foreign enterprises. This, of course, counts on it being FDI through construction (FDIC), which entails the creation of new productive capacity, and not FDI through purchase (FDIP), which entails the purchase of existing productive capacity.

However, there are also potential risks. For example, the presence of foreign commercial firms (with higher levels of pay and/or better equipment and premises) may entice personnel away from public facilities: an ‘internal’ brain drain. The health system may become, or be reinforced as, a ‘two-tier’ system, with high quality care for the rich and poor quality for the poor (Pollock & Price, 2000). The presence of increased health technology in the private sector may encourage governments to invest in such technology in the public sector at the expense of broader social and public health needs. To guard against these, countries may impose limitations on FDI. For example, foreign equity ceilings, tax, land procurement or other discriminatory policies (Chanda 2002a, b, c).¹⁰

Of course, there are likely to be a range of important external factors impacting upon any assessment of FDI (Adlung, 2002). For example, one might expect interactions between commitments made under mode 3/FDI and commitments under other modes of GATS, interactions between health and non-health sectors, such as migration, labour supply, medical education and IT, and effects from other, non-GATS, areas of trade in health services (Ostry, 2001; Sanger, 2002). However, although these are undoubtedly important issues, they are not central to the core focus of this review, and as such are not specifically considered in the discussion presented in Discussion section.

⁹Although not necessarily liability—or cost—free as upfront capital inflow is likely to be off-set by long-term outflow of profits, with a very high rate of return.

¹⁰Although these need to be specified at the outset in the GATS commitments.

Core features of the GATS

For countries considering the liberalization of (the import or export of) FDI within GATS, rather than without, there are four core features of importance.

First, the binding nature of agreements made under GATS. Countries (via the Ministry of Trade) select the service sector(s) they wish to open to FDI. A ‘commitment’ is then made within this sector,¹¹ stating limitations on how much access foreign providers are allowed in specific service sectors and what treatment (less favourable than domestic providers or not) they will receive (see Article XVII of GATS). Critically, commitments are legally binding for an indefinite future. Although changes to them can be made, once 3 years have elapsed since the commitment was made (see Article XXI of GATS), these entail compensation payments if other countries can show that these changes will impact adversely upon them.¹² This is perhaps the most important feature of GATS, as it implies that commitments are potentially irreversible (Pollock & Price, 2000).

Second, GATS only applies to commercial services and/or services provided in a competitive market. It therefore excludes services provided “in the exercise of government authority” (the ‘public sector’).¹³ Thus, public health services that are supplied *neither* on a commercial basis *nor* in competition fall outside the scope of the GATS, while their private equivalent will be covered by the GATS. However, if there is a combination of public *and* private providers, then public providers *are* covered by GATS, creating a ‘binary’ system: either there is a *wholly* public service provider, where health services are not covered by GATS, or there are both private and public providers, in which case public services are provided in competition and GATS would therefore apply (Chanda, 2002a, b, c). This is a significant issue with respect to mode 3, as FDI is, by nature, commercial and thus once engaged may open up the whole of the (public) health sector to commercial activity, which may not be desired (Pollock & Price, 2000).

¹¹ Current GATS commitments may be reviewed at: <http://gats-info.eu.int/gats-info/gatscomm.pl>.

¹² Note that compensation to affected Members does not take the form of cash payments: the Member modifying its commitments must “compensate” by offering new specific commitments in other services sectors/subsectors with a view to restoring the balance of commitments which existed prior to the modification (GATS Article XXI).

¹³ Although there is no clear definition of this. For example, whether services provided by a few small private providers as well as a public monopoly count, or publicly provided services where a charge is made, as in most developing countries.

Third, GATS does not affect member rights concerning market regulation for social policy purposes, such as universal access to care (Adlung, 2002). It *could*, however, affect what *type* of regulations they are allowed to use, although these rules are still in development. For example, there is a ‘necessity test’ that has been instituted for accountancy services which allow governments to deal with any economic and social problem they wish *provided* that the measures/regulations they adopt are not more trade restrictive or burdensome than necessary to achieve the relevant objective. Health objectives are probably among the most important that a government may have so it is important to know just how much space they have for regulating this area. For example, if a country commits its public health insurance system to GATS, for example through mode 3, then there appears to be no social policy protection (Sanger, 2002).

Fourth, countries are only obliged to open to FDI those sectors that have been included in their Schedule of Commitments; which themselves may contain qualifications, such as limitations to foreign equity investment, size limitations on facilities or exclusion from subsidy. The only absolute obligation concerns the most-favoured-nation (MFN) obligation in Article II that requires Members to extend to all other Members the best treatment that they give to their most favoured trading partner, although MFN exemptions can be taken for a limited period (Mashayekhi & Julsaint, 2002).

Literature search, review methodology and results

The search methodology comprised two components. The first, and primary, component was an electronic bibliographic database and website search. The second, supplementary, component was through personal communication with experts in trade in health services, to establish whether any work had been missed in the electronic search, or there was important work in progress. Both of these components are outlined briefly below.

Electronic bibliographic database and website search

An extensive range of health and economic databases were searched (EconLit, ISI, Medline, EMBASE, Grey Literature, OPAC, Cochrane Library Online and Web of Science), using a combination of search terms (FDI, Trade, Health and Health Services) over the period from January 1990 to December 2002, supplemented by a search of web sites relevant to trade in health services.¹⁴

¹⁴ The World Health Organisation, World Trade Organisation, World Bank, International Monetary Fund, United Nations Conference on Trade and Development, United

Where possible, search terms were used across fields concerning title, abstract and subject heading. The search strategy was tailored according to the specific database chosen, such that (combinations of) terms were used in order that the broadest range of literature was identified initially, and then narrowed down as necessary.

Literature search results

The bibliographic databases yielded 67 possibly relevant ‘hits’ which were downloaded (abstracts where possible, titles otherwise) and reviewed. Of these only 19 were deemed relevant and the full paper obtained and reviewed. The websites together yielded 49 potentially important papers, which were obtained and reviewed.¹⁵ A review of the references contained within those papers obtained yielded six additional papers for review. The expert contacts yielded two more relevant references. Thus, in total, 76 papers, books and reports were reviewed fully (marked by * in the reference list). An annotated bibliography of all these 76 papers is available from the author upon request.

Criteria for prioritization of papers

Papers in this area may have a broad or narrow focus, according to whether, for example, they focus upon health specifically or trade more generally, whether they focus upon the experience or viewpoint of a single country, a region, trading network or more globally, and whether they focus upon FDI/mode 3 specifically or GATS/trade in health services more generally. Clearly, the relevance and importance of these papers to the specific issue of FDI/mode 3 within health services trade will differ. Papers identified were therefore categorized according to three dimensions:

1. Sector: concerned with trade generally or health specifically;
2. Geography: country-specific or not;
3. Mode: cover all modes or concerned with mode 3 specifically.

(footnote continued)

Nations Development Programme, WHO South East Asia Regional Office, International Centre for Trade and Sustainable Development, Organization for Economic Cooperation and Development, Commission on Macroeconomics and Health, Harvard University Institute for International Development, London School of Hygiene and Tropical Medicine, Canadian Centre for Policy Alternatives, Pan American Health Organization, ‘STAT-USA’, World Trade Online and International Hospital Federation, all accessed in November 2002.

¹⁵The full results of the literature search by database/web site are available from the author upon request.

These papers were then ‘priority rated’, according to these dimensions, as:

1. *High priority*: papers specifically concerned with health *and* mode 3 *and* were not country-specific;
2. *Medium priority*: papers concerned with trade more generally *or* were not health-specific *or* were concerned with mode 3 *and/or* health, but were country specific; *and*
3. *Low priority*: papers concerned with trade more generally *and* were not health-specific (for example, see Price & Pollock, 1999).

Only those papers rated as medium or high priority were used as the basis for the discussion presented in Discussion section (these are marked by # in the reference list).

Expert consultation

A range of ‘key experts’ in the area of trade in health services were identified from the literature reviewed, through contacts at the World Health Organization and WTO, and also from suggestions made by those initially contacted. A full list of those contacted is available from the author upon request.

These experts were sent a draft copy of this paper and asked for general comments, published or unpublished papers that may have been missed in the review, and current work in progress. This confirmed the results of the main literature search, that there are few publications, and suggested that there are few individuals or institutions currently completing work concerning FDI in health services, highlighting a paucity of research.

These experts were also asked if they would nominate their ‘top 5’ papers concerning FDI and health services, to ‘cross-check’ the rating system applied above. Most suggested that an authoritative body of work has yet to be established in this area, and were reluctant to nominate a ‘top 5’. Of those who were, tentatively, prepared to nominate papers, the consensus was that a ‘top 5’ would include Chanda (2001), Hilary (2001) and Lipson (2001a, b), with the remaining two slots able to be filled by a variety of papers contained within Drager and Vieira (2002). This provides some ‘validity’ check of the results of the literature review, as all of these papers were identified as ‘high priority’.

Discussion: Key issues in FDI and trade in health services

There are considerable gaps in the knowledge base for FDI and health services trade. Most of the literature is ‘data free’, based on theory, assumption or conjecture. It is therefore impossible to fully assess the potential impact of FDI on health, and thus make informed recommendations. This is critical because there is no

time limitation on GATS commitments: commitments made on the basis of inadequate information now will potentially constrain future policy indefinitely. This section therefore outlines the author's perception of the (three) key issues for clarification and research. It is hoped that this may help prioritize where assessment of evidence is required by countries to enable better assessment of the potential impact of FDI on health care and health status.

Extent of health system commercialization is more important than whether investment is foreign or domestic

The foundation for assessing the impact of FDI is the basic health care system (the 'market') in the country: The level of government versus private (including the split between profit and not-for-profit organizations) funding of health care, current demand and supply situation, education and professional supply, rural/urban split, focus on secondary and primary care, etc. This is important for two reasons in particular.

First, FDI is, by definition, only directly relevant to the *private market*. It is therefore important to establish the (potential) size of this market to assess the scope for FDI and its likely impact (e.g. FDI may *cause* a two-tier system, but one may already exist and the relevance is then on the degree to which it is exacerbated, or what regulations are required to militate against it). Second, it could be that 'problems' observed within the health care system/market once FDI is encouraged are not actually related to FDI *per se* but, for example, to there simply being a highly privatized market. That is, there are two components to mode 3: the '*commercial*' and the '*foreign*'. It is not necessarily that the latter causes the real problem, but the former (or vice versa). Thus, FDI may strengthen *or* weaken the health care system, but this depends largely on the existing structure of the *domestic* sector (Janjaroen & Supakankunti, 2002; White & Collyer, 1998).

Thus, the first question is not whether presence in the health care market is *foreign* or not, but whether it is *commercial* or not. Most of the observed impact is likely not to be due to whether the country has a foreign presence, but how big the commercial sector is, and thus whether FDI will increase or establish a commercial presence.¹⁶

It is also worth undertaking to establish the regional context with respect to health and FDI. It could be that the decisions of neighbouring countries impact upon the national decision, and/or impact upon the cost-benefit

ratio of FDI in the domestic circumstance. It may also be that there are valuable lessons to be drawn from neighbouring countries on the experience of FDI that may inform the view of FDI in the following sections. Overall, the extent to which FDI is a 'regional' phenomenon is unclear, but there may well be scope for mutual benefits when there are shared cultures, language, social factors and diseases of importance. Further, the status of the health sector in neighbouring countries may also provide opportunities for more regional trade in health services via FDI. For example, this is occurring to a degree in the provision of hospital services across countries in South East Asia (Chanda, 2001; Janjaroen & Supakankunti, 2002).

Current regulatory environment, especially in health, will determine economic and health impact of FDI

The current regulatory environment, and 'strength', of a country will, in addition to that specifically related to GATS, determine the effectiveness of safeguard measures and the stability of GATS commitments. For example, would the existing legal establishment be able to deal with the case of disputes? Important here is the balance of 'power' between a national regulatory system and potential investors; TNCs in particular, which in many cases are economically far larger than the countries they are seeking to invest in (Schaars & Woodward, 2002). The sustainability and cost-benefit balance of FDI will be determined to a large degree by the level, pace and sequencing of regulatory reform.

In addition to the general regulatory environment, of importance are those regulations that are directly pertinent to health, as health care tends to be amongst (if not the) most heavily regulated sector of a nation's economy. The plethora of regulations in health care may therefore make the impact of FDI, or its possibilities, differ considerably from other sectors. For example, regulation concerning standards of health care, establishments, professional accreditation and mutual recognition, cross-subsidization policies, pro-poor regulations, restrictions on corporate hospitals, conditions placed upon profits, reinvestment and resource transfer to the government, the role of professional bodies and the powers they exercise, medico-legal liability issues and so forth. FDI, as indicated earlier, will have a significant impact upon the domestic system as it opens up what may be a largely government sector to one that is contestable by commercial activity. If there is a desire to protect certain aspects of health care provision, and indeed finance, then the current regulatory system is a key variable, as is the level of development in that system that might be necessary if FDI is to be encouraged/allowed (Lipson, 2001a, b).

A key issue related to this is the interpretation within the GATS system of services "supplied in the exercise of

¹⁶Notwithstanding that foreign commercial presence may affect the competitive structure of the domestic commercial sector, and that foreign providers may behave differently from local commercial providers (e.g. in services provided, market served, pricing, marketing, staffing, etc.).

government authority”, which may be exempted from commitments. This establishes the range of services over which GATS applies, and thus regulation will be applicable, but is subject to interpretation problems and is therefore important to define early on. This, too, has wider implications, as health care will be influenced by non-health FDI. For example, commitments concerning insurance, education and temporary migration. The regulatory environment, and the definition of what is “supplied in the exercise of government authority” may differ here, but there may be possible ‘leakage’ in to the health sector according to the regulatory systems involved.

Finally, consideration is required concerning areas of current, and future, uncertainty in the GATS negotiations, and therefore regulatory measures. For example, Emergency Safeguard Measures (ESM) (GATS article X) allow a country to react if there is proved to be possible or actual, serious injury to ‘domestic service providers’. If agreed, ESM (horizontal or vertical) could help promote confidence in GATS and promote further commitments in sensitive areas, such as health. However, they may also promote distrust and could be abused, especially by developed countries, to block exports from developing countries. The development of suitable ESM is therefore a subject of concern during current negotiations. Another example is the classification of services, as many countries feel that the classification lists used in previous negotiations are inadequate (e.g. obsolete or too aggregated). Many countries have therefore started to use new definitions, or new clusters of services. Although Members have the right to use whatever classifications they wish in commitments, if several Members opt for different classification approaches then the request-offer negotiations could quickly become confused, with parties not negotiating for quite the same service or cluster (Mashayekhi & Julsaint, 2002).

Definitions (of FDI, country objectives, range of health services) are vital in assessing the costs and benefits of FDI

There is a need to establish a range of information specifically related to FDI. The first important issue here is to establish what *constitutes* FDI. This could be based on proportion ownership, in which case what proportion (e.g. 10% is often the minimum, but could be majority ownership at 51% or full ownership at 100%)? Alternatively, it could be based on the management system being foreign or local, investment on an affiliate or non-affiliate basis, or some combination. It is critical to establish this, as the ‘definition’ of FDI will not only influence what is measured as FDI, but may also determine the performance of FDI initiatives. For example, in other sectors equal partnerships appear to

perform poorly, as do initiatives with the government as a partner, whereas majority owned local or foreign enterprises appear to perform equally well (Woodward, 2001).

It is also important to distinguish between ‘for profit’ and ‘not for profit’ FDI. For example, where non-resident nationals of a country may wish to improve the situation in their homeland, rather than necessarily seek large profits, there may be significant differences in the levels and types of FDI, and of course the cost–benefit ratio. This is a particularly relevant case in health services, as there is a significant amount of non-resident, Diaspora based FDI in health (Gupta & Goldar, 2001). It might therefore be useful for countries to breakdown FDI in health between non-resident nationals and ‘foreigners’, as this could provide important policy directions for tapping Diaspora networks for getting FDI in health.

The second important issue here is to establish if the core interest of a country is in inward or outward FDI, or indeed a combination/balance of both. As indicated earlier, this will determine the scope of the analysis with respect to other issues, particularly the expected cost–benefit ratio. A related point is whether there is a FDI ‘national strategy’, and whether there is an agency leading on this aspect of trade. More specifically, whether there is a separate strategy for inducing inward FDI or promoting outward FDI in the health sector (and what relationship, if any, it has to the Ministry of Health).

The third important issue is to establish whether the country is primarily interested in hospital, and/or other institutional investment, or insurance (or indeed other areas, such as medical education), as again this will determine the manner in which most of the other issues are approached.

Finally, it is important to establish the current extent/magnitude of FDI (there is a lack of this basic information globally at present), and its distribution, geographically and between sub-sectors.

Conclusion

Although the health *service* has remained relatively unaffected by trends in globalization, the advent of GATS, within the context of changes in technology, mobility and health care financing, mean that this is unlikely to continue. A key component of increased international trade in health services will be FDI.

However, evidence on the likely impact of increased health service trade liberalization, within GATS commitments or without, is virtually non-existent. Perhaps due to this, most of the literature is speculation about what *might* happen, rather than anything empirically supported or verifiable, with views naturally quite

polarized between those arguing for and against the benefits of liberalization (and GATS commitments). In this paper, an attempt was made to provide a balanced review of the literature concerning FDI in health services, providing an overview of key issues that face countries in considering commitments under the GATS, and/or embarking on trade liberalization more generally.

Three issues were suggested as being of most importance. First, the extent to which the health system of the country concerned is commercialized per se is of more significance than whether investment in it is foreign or domestic. This is because liberalization of the health care market to allow, or encourage, FDI will necessarily create or increase the level of commercialization of that market. This has implications both for attracting and facilitating FDI—that a private market in health care services must exist—and for health service provision and finance—that the private sector will be created and/or expanded. The greatest impact on health care financing, distribution of facilities, access to services, etc., is thus the degree to which health care is *commercial*, not whether it is *foreign*. It is therefore critical that countries consider the current and desired *future* status of private health care finance and provision *before* engaging in FDI (within or without GATS).

Second, a country's current regulatory environment, and 'strength', will significantly determine the economic and health impact of FDI, the effectiveness of safeguard measures and the stability of commitments (under GATS or otherwise). Key here is establishing the likely balance of 'power' between the national regulatory system and potential investors, as FDI is most likely to come from TNCs which, in many cases, will be far larger economically than the countries they are seeking to invest in. Not only might regulations determine the level of FDI, but opening up, or extending, the commercial sector will require standards in care to be established and maintained. Although services "supplied in the exercise of government authority" are exempted from GATS, this is currently subject to interpretation problems, and there is the possibility of commercial 'leakage' from non-health sectors (such as insurance, education and migration). Countries therefore need to determine whether their regulatory regimes will be able to handle (greater) FDI, and if not what measures need to be enacted to do so.

Third, any negotiations will depend upon parties having a common understanding of what is being negotiated. In this respect, the room for interpretation of key definitions is critical to assess. For example, what actually *constitutes* FDI in health (proportion of ownership, and if so what percentage, the management system being foreign or local, investment on an affiliate or non-affiliate basis, etc.). Such definitions will determine what is measured as FDI and thus how the cost–

benefit ratio of FDI is prospectively and/or retrospectively assessed. Similarly for definitions concerning 'for profit' and 'not for profit' FDI, whether FDI covers foreign and/or ex-patriot nationals, and so forth. Without a common understanding of key definitions surrounding FDI it is difficult to make an appropriate assessment of the likely (or actual) costs and benefits that will (be expected to) result from it.

The central conclusion of this paper is that FDI involves the (increased) commercialization of the health care sector, and consequently the attendant risks and benefits that may come from this. The fact that this investment is *foreign* is not as central as some critics suggest—the real issue is how *commercial* the health sector is already. (Of course, if a country is 'invaded' by heavy FDI, especially from TNCs, then 'foreignness' will matter, as FDI differs from the usual investment routes as it involves a real transfer of control). The central recommendation from this paper is therefore that countries take a step back and first think through *this* issue, of the risks and benefits of *commercialization* of their health sector, rather than being sidetracked in to considering the level of *foreign* investment.

Finally, given the data vacuum that exists with respect to the impact of FDI, and GATS more specifically, there is clearly a substantial research agenda to be pursued before one can begin to make well-informed observations about the health and economic impact of FDI. For instance, the economic and health impact of regulatory changes required due to FDI, the added costs/benefits of engaging in GATS commitments concerning FDI compared with other, non-GATS, agreements, and the consequences of FDI for equity of access to health services. Given the importance of trade liberalization and its potential impact on the health sector, it is recommended that the academic sector, international organizations and individual countries undertake to give priority to such research.

Acknowledgements

This paper was funded by the World Health Organization. The author would like to extend his appreciation to Dr. Nick Drager of the WHO for his advice and support, to the experts contacted for their contribution to this paper, and to two anonymous referees whose comments greatly improved the clarity of the paper. The usual disclaimer applies.

References

- Adlung, R. (2002). Health services in a globalising world. *EuroHealth*, 8, 18–21.

- Adlung, R., & Carzaniga, A. (2001). Health services under the General Agreement on Trade in Services. *Bulletin of the World Health Organisation*, 79, 352–364 *#.
- Bajpai, N., & Sachs, J. (2000). *Foreign Direct Investment in India: issues and problems*. Development Discussion Paper 759, Harvard Institute for International Development, Harvard University, Boston *.
- Bettcher, D., Yach, D., & Guindon, E. (2000). Global trade and health: Key linkages and future challenges. *Bulletin of the World Health Organisation*, 78, 521–534 *#.
- Chanda, R. (2001). *Trade in health services*. Paper No. WG4:5, Commission on Macroeconomics and Health, WHO, Geneva *#.
- Chanda, R. (2002a). Trade in health services. *Bulletin of the World Health Organisation*, 80, 158–163 *.
- Chanda, R. (2002b). *Trade in health services*. Paper presented at Assessment of GATS and Trade in Health Services: An International Consultation on Monitoring and Research Priorities, WHO, Geneva, 9–11 January, <http://www.who.int/health-services-trade/> *.
- Chanda, R. (2002c). Trade in health services. In N. Drager, & C. Vieira (Eds.), *Trade in health services: global, regional and country perspectives*. Washington, DC: PAHO (Chapter 3) *.
- Drager, N., & Vieira, C. (Eds.), (2002). *Trade in health services: global, regional and country perspectives*. Washington, DC: PAHO *.
- Gupta, I., & Goldar, B. (2001). *Commercial presence in the hospital sector under GATS: A case study of India*. Delhi: WHO SEARO *#.
- Hilary, J. (2001). *The Wrong Model: GATS, trade liberalization and children's right to health*. London: Save the Children *#.
- HMSO (2000). *Eliminating world poverty: making globalisation work for the poor*. White Paper on International Development, HMSO, London.
- IMF (1993). *Balance of Payments Manual* (5th ed.). Washington, DC: IMF.
- Janjararoen, W., & Supakankunti, S. (2002). International trade in health services in the millennium: The case of Thailand. In N. Drager, & C. Vieira (Eds.), *Trade in health services: Global, regional and country perspectives*. Washington, DC: PAHO (Chapter 8) *#.
- Lipson, D. (2001a). *GATS and Trade in Health Insurance Services*. Paper No. WG4:7, Commission on Macroeconomics and Health, WHO, Geneva *#.
- Lipson, D. (2001b). The World Trade Organisation's health agenda: Opening up the health services markets may worsen health equity for the poor. *British Medical Journal*, 323, 1139–1140 *#.
- Mashayekhi, M., & Julsaint, M. (2002). *Assessment of trade in services in the context of the GATS 2000 negotiations*. T.R.A.D.E. Working Paper 13, South Centre, Geneva *#.
- ODI (1997). *Foreign Direct Investment flows to low-income countries: a review of the evidence*. Briefing Paper No. 1997(3), Overseas Development Institute, London.
- Ostry, A. (2001). International trade regulation and publicly funded health care in Canada. *International Journal of Health Services*, 31, 475–480 *#.
- Pollock, A., & Price, D. (2000). Rewriting the regulations: How the World Trade Organisation could accelerate privatization in health care systems. *The Lancet*, 356, 1995–2000 *#.
- Price, D., & Pollock, A. (1999). How the World Trade Organisation is shaping domestic policies in health care. *The Lancet*, 354, 1889–1892.
- Sanger, M. (2002). *Reckless abandon: Canada, the GATS and the future of health care*. Ottawa: Canadian Centre for Policy Alternatives *#.
- Schaars, C., & Woodward, D. (2002). *Measuring globalisation of health services*. WHO Internal Discussion Paper, WHO/EIP/HDE, Geneva *#.
- Sinclair, S., & Grieshaber-Otto, J. (2002). *Facing the facts: a guide to the GATS debate*. Ottawa: Canadian Centre for Policy Alternatives *.
- UNCTAD (2001). *World Investment Report, 2001: promoting linkages*. Geneva.
- White, K., & Collyer, F. (1998). Health care markets in Australia: Ownership of the private hospital sector. *International Journal of Health Services*, 28, 487–510 *#.
- Woodward, D. (2001). *The next crisis? Direct and equity investment in developing countries*. London: Zed Books *#.
- Yach, D., & Bettcher, D. (1998a). The globalisation of public health I: Threats and opportunities. *American Journal of Public Health*, 88, 735–738.
- Yach, D., & Bettcher, D. (1998b). The globalisation of public health II: The convergence of self-interest and altruism. *American Journal of Public Health*, 88, 738–741.
- Zhang, Q., & Felmingham, B. (2002). The role of FDI, exports and spillover effects in the regional development of China. *The Journal of Development Studies*, 38, 157 *.

Further reading

- Achouri, H., & Achour, N. (2002). Health services in Tunisia in the light of the World Trade Organisation agreements. In N. Drager, & C. Vieira (Eds.), *Trade in health services: Global, regional and country perspectives*. Washington DC: PAHO (Chapter 16) *#.
- Adams, O., & Kinnon, C. (1998). *A public health perspective, international trade in health services*. Geneva: UNCTAD/WHO *#.
- Adlung, R., & Carzaniga, A. (2002). Health services under the General Agreement on Trade in Services. In N. Drager, & C. Vieira (Eds.), *Trade in Health Services: global, regional and country perspectives*. Washington, DC: PAHO (Chapter 2) *.
- Arkell, J. (2002). *Key challenges for measuring GATs Mode 3: commercial presence*. Paper presented at Assessment of GATS and Trade in Health Services: An International Consultation on Monitoring and Research Priorities, WHO, Geneva, 9–11 January, <http://www.who.int/health-services-trade/> *#.
- Ascher, B. (2002). The case of the United States of America. In N. Drager, & C. Vieira (Eds.), *Trade in health services: Global, regional and country perspectives*. Washington, DC: PAHO (Chapter 13) *#.
- Baris, E., & McLeod, K. (2000). Globalization and international trade in the Twenty-First Century: Opportunities for and threats to the health sector in the south. *International Journal of Health Services*, 30, 187–210 *.
- Bautista, M., Macam, M., & Yap, M. (2000). *International trade in health services: the case of the Philippines*. Manila: WHO WPRO *#.
- Benavides, D. (2002a). *Trade policies and export of health services: a development perspective*. Paper presented at

- Assessment of GATS and Trade in Health Services: An International Consultation on Monitoring and Research Priorities, WHO, Geneva, 9–11 January <http://www.who.int/health-services-trade/> *#.
- Benavides, D. (2002b). Trade policies and export of health services: A development perspective. In N. Drager, & C. Vieira (Eds.), *Trade in Health Services: global, regional and country perspectives*. Washington, DC: PAHO (Chapter 5) *.
- Bettcher, D., & Lee, K. (2002). Globalization and public health. *Journal of Epidemiology and Community Health*, 56, 8–17 *#.
- Cave, W. (2002). *The manual on statistics of international trade in services*. Paper presented at Assessment of GATS and Trade in Health Services: An International Consultation on Monitoring and Research Priorities, WHO, Geneva, 9–11 January <http://www.who.int/health-services-trade/> *.
- Dunning, J. (1998). *Globalization, trade and foreign direct investment*. Amsterdam: Elsevier Science *.
- Farba, L. (2001). *A contribution to the international conference on trade and health*. Source unknown *#.
- Fujita, M. (2002). *Assessment of GATS and trade in health services: an international consultation on monitoring and research priorities*. Paper presented at Assessment of GATS and Trade in Health Services: An International Consultation on Monitoring and Research Priorities, WHO, 9–11 January, <http://www.who.int/health-services-trade/> *#.
- Gomez-Dantes, O., Frenk, J., & Cruz, C. (1997). Commerce in health services in North America within the context of the North American Free Trade Agreement. *Pan American Journal of Public Health*, 1, 460–465 *#.
- Gupta, I., & Glodar, B. (2002). *Commercial presence in the hospital sector in India: Results and research challenges*. Paper presented at Assessment of GATS and trade in health services: An International Consultation on Monitoring and Research Priorities, WHO, Geneva, 9–11 January, <http://www.who.int/health-services-trade/> *#.
- Hilary, J. (2002). *The wrong model: GATS, trade liberalization and children's right to health*. Paper presented at Assessment of GATS and trade in health services: An International Consultation on Monitoring and Research Priorities, WHO, Geneva, 9–11 January, <http://www.who.int/health-services-trade/> *.
- Houyuan, X. (1998). The case of China. International trade in health services: A development perspective. In O. Adams, & C. Kinnon (Eds.), *A public health perspective, international trade in health services*. Geneva: UNCTAD/WHO (Chapter 12) *#.
- Johns, D. (Unknown). *Trade and health: the South African perspective*. Source unknown *#.
- Kanavos, P., & McKee, M. (2000). Cross-border issues in the provision of health services: Are we moving towards a European health care policy? *Journal of Health Services Research and Policy*, 5, 231–236 *#.
- Karsenty, G. (2002). *International trade in services statistics and trade in health services*. Paper presented at Assessment of GATS and Trade in Health Services: An International Consultation on Monitoring and Research Priorities, WHO, Geneva, 9–11 January, <http://www.who.int/health-services-trade/> *.
- Kierzkowski, H. (2002). Trade and public health in an open economy: a framework for analysis. In N. Drager, C. Vieira (Eds.), *Trade in health services: Global, regional and country perspectives*. Washington, DC: PAHO (Chapter 4) *.
- Koivusalo, M. (2001). World Trade Organisation and trade-creep in health services. *Journal of Health Services Research and Policy*, 6, 65–67 *#.
- Koivusalo, M., & Rowson, M. (2000). The World Trade Organisation: Implications for health policy. *Medicine, Conflict and Survival*, 16, 175–191 *#.
- Laurell, A., & Ortega, M. (1992). The free trade agreement and the Mexican health sector. *International Journal of Health Services*, 22, 331–337 *.
- Leon, F. (2002). The case of the Chilean health system, 1983–2000. In N. Drager, & C. Vieira (Eds.), *Trade in health services: Global, regional and country perspectives*. Washington, DC: PAHO (Chapter 12) *#.
- Lipson, D. (2002a). *Measurement challenges and issues in assessing health system impact of health services trade and GATS*. Paper presented at Assessment of GATS and Trade in Health Services: An International Consultation on Monitoring and Research Priorities, WHO, Geneva, 9–11 January, <http://www.who.int/health-services-trade/> *.
- Lipson, D. (2002b). GATS and health services: Implications for EU candidate countries. *Eurohealth*, 8, 39–41 *#.
- MacLehose, L., & McKee, M. (2002). *Enlargement of the European Union: Health and accessions: managing the transition*. Paper presented at Assessment of GATS and Trade in Health Services: An International Consultation on Monitoring and Research Priorities, WHO, Geneva, 9–11 January, <http://www.who.int/health-services-trade/> *.
- Ostry, A., Barer, M., Cardiff, K., & Evans, R. (Eds.), (2002). *Trading away health? Globalization and health policy*. Report from the 14th Annual Health Policy Conference of the Center for Health Services and Policy Research, October, University of British Columbia, Vancouver, Discussion paper #02:10D *#.
- PAHO (2002). Trade in health services in the region of the Americas. In: N. Drager & C. Vieira (Eds.), *Trade in Health Services: Global, regional and country perspectives*. Washington, DC: PAHO (Chapter 10) *#.
- Sabri, B. (2002). The Eastern Mediterranean Region perspective. In N. Drager, & C. Vieira (Eds.), *Trade in health services: Global, regional and country perspectives*. Washington, DC: PAHO (Chapter 15) *#.
- Sbarbaro, J. (2001). *Trade liberalization in health insurance: Opportunities and challenges: the potential impact of introducing or expanding the availability of private health insurance within low and middle income countries*. Paper No. WG4:6, Commission on Macroeconomics and Health, WHO, Geneva *.
- Sein, T. (2002). *Assessment of GATS, monitoring and research priorities: a perspective from WHO's Southeast Asia region*. Paper presented at Assessment of GATS and Trade in Health Services: An International Consultation on Monitoring and Research Priorities, WHO, Geneva, 9–11 January, <http://www.who.int/health-services-trade/> *.
- Suseno, U. (2001). Impact of globalisation and trade liberalization on health sector. Source unknown *#.
- Tarabusi, C., & Vickery, G. (1998). Globalization in the pharmaceutical industry, part II. *International Journal of Health Services*, 28, 281–303 *.

- Tata, S. (2002). *GATS—data needs and issues to be considered for preparing a country position*. Paper presented at Assessment of GATS and Trade in Health Services: An International Consultation on Monitoring and Research Priorities, WHO, Geneva, 9–11 January <http://www.who.int/health-services-trade/> *.
- Timmermans, K. (2002). Overview of the South-East Asia Region. In N. Drager, & C. Vieira (Eds.), *Trade in health services: Global, regional and country perspectives*. Washington, DC: PAHO (Chapter 7) *.
- US International Trade Commission (1997). *General Agreement of Trade in Services: examination of the schedules of commitments submitted by Asia/Pacific trading partners*, Washington, DC *#.
- Vellinga, J. (2002a). *Canada: health services and GATS*. Paper presented at Assessment of GATS and Trade in Health Services: An International Consultation on Monitoring and Research Priorities, WHO, Geneva, 9–11 January, <http://www.who.int/health-services-trade/> *.
- Vellinga, J. (2002b). An approach to trade and health at Health Canada. In N. Drager, & C. Vieira (Eds.), *Trade in health services: Global, regional and country perspectives*. Washington, DC: PAHO (Chapter 14) *.
- Vieira, C. (2002). *Health services trade information in the Americas*. Paper presented at Assessment of GATS and Trade in Health Services: An International Consultation on Monitoring and Research Priorities, WHO, Geneva, 9–11 January, <http://www.who.int/health-services-trade/> *.
- Weigal, D., Gregory, N., & Wagle, D. (1997). *Foreign Direct Investment. Lessons of Experience Number 5*, International Finance Corporation (World Bank), Washington, DC *#.
- WHO/WTO (2002). *WTO Agreements and Public Health: A joint study by the WHO and the WTO Secretariat*. WHO/WTO, Geneva. *#.
- Wibulpolprasert, S. (2002). *Policy issues/questions in services trade affecting the health sector*. Paper presented at Assessment of GATS and Trade in Health Services: An International Consultation on Monitoring and Research Priorities, WHO, Geneva, 9–11 January <http://www.who.int/health-services-trade/> *.
- Widiatmoko, D., & Gani, A. (2002). International relations within Indonesia's hospital sector. In N. Drager, & C. Vieira (Eds.), *Trade in health services: Global, regional and country perspectives*. Washington, DC: PAHO (Chapter 9) *#.
- Woodward, D. (2002). *Trade in health services: conceptual frameworks, issues and constraints*. Paper presented at Assessment of GATS and Trade in Health Services: An International Consultation on Monitoring and Research Priorities, WHO, Geneva, 9–11 January, <http://www.who.int/health-services-trade/> *#.
- Woodward, D., Drager, N., Beaglehole, R., & Lipson, D. (2002). Globalization, global public goods and health. In N. Drager, & C. Vieira (Eds.), *Trade in health services: Global, regional and country perspectives*. Washington, DC: PAHO (Chapter 1) *#.
- Working Group 3 (2002). *Summary of conclusions*. Paper presented at Assessment of GATS and Trade in Health Services: An International Consultation on Monitoring and Research Priorities, WHO, Geneva, 9–11 January, <http://www.who.int/health-services-trade/> *#.
- Working Party of the Trade Committee, OECD (2002). *Managing 'request-offer' negotiations under the GATS*. Geneva: OECD *#.
- World Bank, (Annual). *DEC notes*. Washington, DC *.
- Wu, Y. (1997). China's health care sector in transition: Resources, demand and reforms. *Health Policy*, 39, 137–152 *#.
- Zarilli, S., & Kinnon, C. (Eds.), (1998). *International trade in health services: A development perspective*. Geneva: UNCTAD & WHO *#.
- Zarilli, S. (2002a). The case of Brazil. In N. Drager, & C. Vieira (Eds.), *Trade in health services: global, regional and country perspectives*. Washington, DC: PAHO (Chapter 11) *#.
- Zarilli, S. (2002b). Identifying a trade-negotiating agenda. In N. Drager, & C. Vieira (Eds.), *Trade in health services: Global, regional and country perspectives*. Washington, DC: PAHO (Chapter 6) *.