

TRADE IN HEALTH AND HEALTH-RELATED SERVICES IN THE ENGLISH-SPEAKING CARIBBEAN: THE CASES OF TRINIDAD AND TOBAGO, AND ST. LUCIA

Introduction

The purpose of these case studies will be to examine trade in health and health related services for its potential as a possible vehicle for future economic development. In keeping with the Term's of Reference for this investigation, the case studies will address the following issues:

1. What is the potential scope for trade in health services in the Caribbean?
2. What are some success stories and how might they be replicated?
3. Why don't we see more trade in this area currently?
4. What are the specific supply-side constraints to growth in this area?

These two countries were selected as it was felt that they were good examples of the growing significance of the tourist and service sector in the economies of the Caribbean, as well as the increasing interest in health tourism and trade in health services as a critical economic development strategy in general, and as one way of the diversifying the tourism product, in particular.

Table 1: Main Indicators of Social and Economic Development: St. Lucia, Trinidad and Tobago^{a)}

| Indicators | Trinidad | St Lucia |
|----------------------------------|-----------|-----------|
| Population | 1,282,400 | 160,000 |
| GDP Per Capita (PPP US\$ - 2001) | 9,100 | 5,260 |
| GDP Growth Rate | 6.7 | 2.0 |
| Health Expenditure p.c. | 468 (PPP) | 272 (PPP) |
| - As a % of GDP: | | |
| - Public | 2.3% | 2.6% |
| - Private | 2.2% | 1.6% |
| Human Development Index | 0.802 | 0.772 |
| Life expectancy | 74.1 | 72.8 |
| Infant Mortality Rate | 18.5 | 12.0 |
| Crude Birth Rate | 14.1 | 17.3 |
| Unemployment | 11 | 20.4 |

a). Most recent years

Source: Caribbean Development Bank Annual Economic Review 2003. The State of the World's Children 2004. Regional Core Health Data System – Country Profiles 2002.

In addition, the economic profile and situations in these two countries are such that they suggest different approaches that could be (and are likely to be) taken in the support and promotion of health tourism and trade in health services. Trinidad and Tobago is a much larger country and enjoys higher levels of development as indicated by the GDP per capita, the HDI, and its GDP growth rate.

Methodology

The primary methods for data collection were the examination of the relevant secondary data, information and reports, as well as in-depth interviews with key informants (in-person or by phone) in two Caribbean countries: Trinidad and Tobago and St. Lucia. These included Ministry of Health officials and representatives of health insurance companies, commerce organisations, regional and international organisations, and professional associations. Country-specific analyses were supplemented by work on the nature and extent of involvement of relevant regional bodies, such as PAHO/CPC, the RNM, the CDB the CSME secretariat – all based in Barbados. Additional success stories were examined through telephone interviews and internet searches. Interviews were conducted using an interview guide/questionnaire specifically designed and developed for this purpose.¹

Data collection focused on:

1. Policy framework in the health sector and relevance to expanded trade in health services
2. Regulations, licensing, accreditation, registration, and means testing requirements in the health sector related to establishing medical services catering to foreign clients.
3. Regulations and procedures related to FDI in the health sector (rules of commerce, etc.)
4. Regulation and promotion of the insurance sector.
5. Regulation and promotion of tourism and health tourism in particular.

Background to Trade in Health Services

A number of recent developments have helped to spur the rapid changes now taking place in the traditional trade relations between developed and developing countries. In the specific area of health, these changes have been especially swift and large, and as Wasserman et al [1999] have noted:

New forces are realigning the form of access to biotechnology, information technology, pharmaceuticals, direct health services, insurance coverage schemes, and the employment opportunities they entail

¹ Copies of the interview guide as well as a list of persons interviewed in both countries may be found in Annex I & II.

in ways and such to an extent that the demand, consumption and provision of health care and health services are increasingly able to take on new dimensions not hitherto thought possible or feasible. As the paper further observes, when to that package of forces is added

- § the increasing privatisation of health care;
- § the expansion of skilled health service personnel in the developing countries for whom there must now be greater incentives to retain them in their host countries;
- § the improvement of services and facilities in developing countries such that the possibilities for the export of a good and even superior product can be contemplated;
- § the greater availability of public information;
- § the growth in tourism, as well as the movement and migration of skilled people, and the
- § the presence of affiliates of foreign manufacturing and other production firms;

it is not difficult to understand how and why this confluence of circumstances and developments has suggested – notwithstanding the notes of caution sounded by some [Belsky et al 2004; Pollock & Price, 2003] - to interests in both the public and private sectors that there are significant growth opportunities to be captured and exploited.

In the Caribbean these forces have been spurring – albeit in fairly sporadic way - great interest in this area. In addition, a number of Caribbean governments have been making commitments – under the GATS agreements – in respect of trade in health and other services. These are detailed in Table 2 below. It will be immediately seen that when compared to St. Lucia, the government of Trinidad and Tobago have made commitments in many more areas. Thus for example, in Trinidad & Tobago commitments have been made in the professional, business and financial, health, tourism and recreational and the transportation services. In St. Lucia, commitments have been made in only five areas and within these they are been fairly circumscribed.

While these might present opportunities for the countries as well as for those wishing to invest in these countries, it is not all clear that there has been sufficient investigation of the capacities of these countries to beneficially participate in the competitive environments being created. This review will begin to look at some of the opportunities and constraints on the promotion of trade in health and health-related services as a possible vehicle for future social and economic development. Through the analysis of these country situations it is anticipated that important conclusions may be drawn, and lessons learned about what could be appropriate strategies and approaches for the tourist-based economies of most of the countries in the region.

Table 2: List of Commitments made under the GATS Agreements. Trinidad and Tobago, St. Lucia

| Sector | Sub Sector/Activity | | | |
|-------------------------------|---|---|---|---|
| | Trinidad & Tobago | Limitations on Market Access/National Treatment | St. Lucia | Limitations on Market Access/National Treatment |
| Business Services | Professional Service ≠ Legal Consultancy in International Law ≠ Patent Agents' Services ≠ Computer and Related Services ≠ Software Development Services Information Services Research & Development Services ≠ Research and Development in Natural Services ≠ Research and Development in Social Sciences and Humanities Other Business Services ≠ International marketing | None | ---- | ---- |
| Communication Services | ≠ Telecommunication services ≠ Other telecommunication services ≠ Mobile (satellite-based) ≠ Teleconferencing ≠ Mobile (terrestrial based) | 1. Until 2010 bypass of the network of exclusive public operator not permitted; 2. Internet and Internet access; teleconferencing services – unconfirmed to be negotiated with exclusive provider 3. Mobile tel. Services – none as of 2010 | ---- | ----- |
| Educational Services | ≠ Specialist Teachers ≠ Tertiary Level Lecturers | None - except for Registration and certification requirements | ----- | ----- |
| Financial Services | Insurance and Insurance-related Services ≠ Re-Insurance | None - except for Registration and Certification requirements) | Insurance and Insurance-related Services Re-insurance | Only corporate entities are allowed to conduct business. The Registrar of Insurance must first register all such entities. Also work Permit regulations |

| | | | | |
|---|--|--|--|--|
| Health-Related and Social Services | Hospital Services § Hospital Services § Dental Services § Veterinary Services | None – except for Registration and Certification requirements) | Hospital Services | Subject to horizontal limitations concerning work permit regulations, Medical Registration and Certification and Medical Officers Ordinance. |
| Tourism and Travel Related Services | Hotels and Restaurants ∄ Hotel and Restaurant Development (Construction) ∄ Hotel Management Travel Agencies and Tour Operator Services | None | Hotel and restaurant Development Operations | Hotel and Resort Devt. and Operation in excess of 100 rooms. Other limitations are restricted to managerial and specialist levels; also subject to horizontal work permit regulations. |
| 10. Recreational, Cultural and Sporting Services | Entertainment Services ∄ Entertainment Services Sporting and Other Recreational Services ∄ Sporting and Other Recreational Services | None | Entertainment Services ∄ Entertainment Services Sporting and Other Recreational Services ∄ Sporting services | None |
| 11. Transport Services | Maritime Services ∄ Dry Docking, Ship Repair, Boat Building, and Ship Management ∄ Navigation Aid and Communication ∄ Ship Surveys | | Maritime Transport Services ∄ International Passenger ∄ Freight Transportation Services Services Auxiliary to all modes of transport ∄ Trans-shipment services. Other Transport Services Free Zone Operations | None – except for horizontal limitations concerning work permit limitations |

Source: CARICOM WTO commitments – compiled by the Caribbean single Market Secretariat, Barbados

SPECIFIC CASE STUDIES

A: Trinidad & Tobago

The Economy

The Trinidad and Tobago economy has - between 1994-2003, performed fairly well – enjoying as it did, an average annual GDP growth rate (constant prices) of 4.6%. After the downturns of the late 1990s, greater economic activities in the petroleum and non-petroleum sectors contribute to the positive outputs. In 2003, real output in the energy sector grew by 3.2% and in the non-energy sector by 2%. In the non-energy sectors the performance was however mixed - with negative growth in Agriculture, Finance, Insurance and Real Estate, but positive growth in the Government, Hotel, Education and Personal Services sectors. [Economic Bulletin, 2003]

In Table 1, it will be seen that while the non-petroleum and service sectors have been significant contributors to the economy, the tourist sector in particular has however, never been a major contributor to GDP and economic growth.

Table T1: Sectoral Composition (%) of Gross Domestic Product – Constant 1985 Prices, Selected years.

| Sector | 1992 | 1996 | 2000 | 2003 |
|----------------------------------|------|------|------|------|
| Agriculture | 2.5 | 2.1 | 1.4 | 1.1 |
| Petroleum(Oil) | 23.6 | 29.1 | 31.3 | 31.4 |
| Manufacturing | 9.2 | 7.0 | 7.1 | 6.8 |
| Electricity and Water | 1.5 | 1.3 | 1.7 | 1.2 |
| Construction and Quarrying | 8.4 | 7.8 | 7.5 | 7.9 |
| Hotels and Guest Houses | 0.5 | 0.6 | 0.4 | 0.4 |
| All Other Services ^{a)} | 54.5 | 50.6 | 51.1 | 52.4 |

Source: Caribbean Development Bank. Social and Economic Indicators. 2003. Vol XIV

NB: The columns will not add up to 100% as the contributions of “Imputed Services Charges” and Values Added Tax have not been included in the table.

a) This category includes Distribution and Restaurants, Transport and Communication, Financial and Business Services, Government Services, Other services.

While the “all other Service Sector” accounted for approximately one-half of GDP, the specific Hotels and Guest Houses sector has rarely accounted for more than 1% of GDP. In 2003, it was down to a mere 0.3%. On the other hand, the dominance of the Oil and Petroleum sector is clear - accounting for 31% of GDP in 2003 – up from 24% in 1992.

At the same time, in comparison with other countries in the Caribbean, Trinidad and Tobago has never been a major tourist destination – especially for those in search of the

more traditional “sand, sea and surf” packages. Figures for 2001 show that in the Caribbean region, Trinidad and Tobago ranks at # 8 (out of 10) for the visitors from the UK and Canadian markets; and #13 (out of 15) for those from the US market [Ministry of Tourism, 2004]. In Table 2 it will be seen that TT lags behind countries such as Jamaica, Barbados, and the Bahamas, in terms of the arrivals by air or cruise ships, as well as in terms of tourist expenditures and the contribution of the sector to GDP. The large majority (approximately 86%) of the visitors go to Trinidad (that is, vs. Tobago). However, there are some differences in the origin – and therefore perhaps also in the demands - of the visitors to the two islands of this twin-island republic. In Trinidad, the largest portion of the air arrivals comes from North America (49%) and the Caribbean (27%), whereas in Tobago, Europe accounts for about 75% of all air arrivals.

Table T2: Air and Cruise Ship Arrivals, and expenditure levels, according to destination

| Country | Tourist Arrivals 2003 ('000s) | Cruise Ship arrivals - 2003 ('000s) | Ratio of Visitor Expend. To Merchandise Exports ^{a)} | Contribution to GDP ^{a)} % | Expenditure per capita ^{a)} (US\$) |
|-------------------|-------------------------------|-------------------------------------|---|-------------------------------------|---|
| Antigua | 224.0 | 385.7 | 6.9 | 63.4 | 4,054 |
| Barbados | 531.2 | 559.1 | 2.6 | 33.0 | 2,659 |
| Jamaica | 1,350.3 | 1,132.6 | 1.0 | 21.3 | 1,774 |
| St. Lucia | 276.9 | 393.3 | 5.1 | 63.8 | 1,774 |
| The Bahamas | 1,428.6 | 2,970.2 | 4.6 | 44.0 | 5,948 |
| Trinidad & Tobago | 408.3 | 55.5 | 0.08 | 3.6 | 164 |

a) 2000 data.

Source: Caribbean Tourism Organisation: www.onecaribbean.org

A further breakdown of the figures shows that in Trinidad in 2003, only 29% came for leisure/beach/vacation. The rest were there to visit friends and relatives, or for business and conventions. In Tobago on the other hand, the large majority (76%) was there for leisure/beach/vacation.

The relatively low occupancy rates of the hotels and guest houses in Trinidad and Tobago are an indication of the underutilisation of existing capacities, and therefore perhaps also the relatively modest significance of tourism in the economy: between 2001-2003 annual average occupancy levels were 42%, 34% & 29% for each year, and rarely exceeded 50%. In the Carnival months of January-March there is a slight increase – reaching 57% in the Guesthouses in 2001.

Opportunities for Trade in Health Services: Defining Comparative Advantage

The conclusion that perhaps needs to be drawn from the above data is that any initiative to develop health tourism and trade in health services will find that there is room for expansion. In this regard, a number of individuals within the private sector indicated that

this was indeed an insufficiently exploited area, there was therefore urgent need for movement away from the more traditional tourism product, and greater product diversification. The relatively recent articulation of the government's overall objective to achieve developed country level socio-economic indicators by the year 2020 (Vision 2020) may provide some added impetus to the search for growth and development strategies for the health sector. Health, and the social infrastructure are two of the key areas targeted for specific focus.

However, in this economic environment, the potential and attractiveness of trade in health services is likely to be shaped not so much by the existence of a large tourist market within the country, as it is by at least three other considerations or realities:

↓ The existence of a potentially large off-shore and foreign clientele within the oil and petroleum sectors. Providing reliable and high quality health services for growing off-shore activities – could help to improve the quality of the enabling and supportive environments for these and other FDI's into the region. In other words, there is potential for the development of an important linkage industry;

↓ Trinidad and Tobago is located in close proximity to many islands and countries – especially in the Eastern and Southern Caribbean where tourism has come to be the main economic activity and source of growth and development, but where health and medical facilities are seriously underdeveloped, and nationals from those countries must frequently seek health services in Trinidad and Tobago. Efforts to provide treatment services and facilities for a tourist market could then refer to Trinidad as a critical regional centre of excellence for the supply of those services.

↓ The growth of health tourism and trade in health and health related services could be a profitable area for greater economic diversification outside of the now dominant oil and petroleum sector, and provide outlets for the growing entrepreneurial cadres in that country. The intellectual and skill resources and levels have grown significantly over the past 10-20 years, and there is need to encourage ventures operating singly, collectively, or in partnerships with foreign interests so as to both retain the human resources, and further the development process. In this regard, the history of the economic development process has been such that the early investment in and development of the primary sectors and the steel industry has meant that there are now basic support infrastructures onto which the expansion of the kinds of services envisaged could be profitably grafted.

However, an important question is why – in spite of the fact that many [Gonzales Sancho & Brenzel (2001); Alleyne 2001; Brenzel & Le Franc, 2001] governments have recognised the possible benefits and potential of development in this area – has there been so little actual movement in this direction from either the public or private sectors? In the new strategic plan now being developed at the Caribbean Development Bank, health will be an important and priority sector, and initiatives in health trade and health tourism would be encouraged. However in spite of earlier discussions at the government and country levels follow-up has been almost non-existent. Also, although the Regional Negotiating Machinery had commissioned an earlier study on Health tourism and related Services [Gonzales et al 2001], to date there has been little systematised focus on health trade related activities. In the current discussions around the Caribbean Single Market-

Economy these types of trading activities have not really received a great deal of attention. One reason no doubt has to do with the lack of resources to focus on this area; but more generally, one probable answer is that given the serious inadequacies and deficiencies in the public health sector [Alleyne 2001: 7], official interest has been minimised by the recognition that there may not be a product that could be offered on an international market. Even more importantly, governments are perhaps more concerned with addressing and redressing the many and serious problems – [for example, the relatively poor state of basic community health and sanitation facilities, and more recently, a burgeoning HIV/AIDs problem] in the public health sector. Historically, the governments in the region have accepted that it is part of their function to provide health as an individual right and public good. To this end, the most governments have endeavoured to maintain the budgetary allocations to the health sector. Even so, available data indicate that these allocations - at 2.3% of GDP [Human Development Report 2003] - are below that spent in the developed world, as well as that currently recommended by WHO/PAHO. Further, many Caribbean governments have difficulty in keeping pace with population growth, and the real levels of health expenditure tend to be volatile [OECS Human Development Report, 2002]. The budgetary difficulties have then made the satisfactory provision of the desired quality of health care problematic, and almost all governments are now searching for new and innovative ways to finance and provide more adequate public health services. Since this is likely to be an overwhelming priority in the foreseeable future, government involvement and/or support of initiatives in health tourism would perhaps be more likely where the benefits for the health and other sectors in the public arena are clear.

From the discussions with key informants in the private and public health sectors, it seems clear that the initiatives or ventures in health tourism and trade in health services is and perhaps should be a private sector initiative. The share of private health financing has grown significantly over the past 15-20 years; by 2000 and expressed as a percentage of GDP, the proportion was the same [UNDP 2003]; it also accounted for approximately 55-60% of total health financing [Gonzalez et al 2001]. This probably provides both opportunity and impetus for the blossoming interest in this area. At the same time, many recognise that while the climate and general ambience are important natural assets that could be exploited, the small size of the country and its distance from the major markets could be a possible constraint. It would therefore necessary to carefully identify the most feasible niches, and to try to ensure price competitiveness. Table 3 gives the range of products by category that is being considered as feasible, and in which there has been an expression of interest.

Table T3: List of Products being ‘traded’, or in which there is active interest – Trinidad & Tobago

| Wellness | | Treatment | Rehabilitation |
|-----------------------------|---------------|--|---|
| Spas | | Elective surgery | Dialysis |
| Lifestyle/healthy vacations | | Cardiothoracic services | Recuperation, convalescence, and recovery; support services |
| Alternative Medicine | Complementary | Eye Surgery | |
| | | Orthopaedic surgery; e.g. Joint replacements | |
| | | Plastic/cosmetic surgery | |
| | | Nephrology | |
| | | Oncology | |

Wellness and healthy life-style services

With respect to “wellness” products - and which are, or would be, provided primarily through the tourism industry - there is great interest, as well as capacity in both islands to support the movement of persons for the consumption of the product. Indeed, the Caribbean Tourism Organisation’s officials point out that hotels – especially those at the upper end of the scale – must now provide high quality spas and other body health facilities if they are to remain competitive; the demand is very high especially among the younger, affluent and upwardly mobile visitors. The kinds of personnel required for the delivery of the various kinds of therapies and healthy life-style programmes envisaged would also be unlikely to significantly encroach on those needed for the delivery of treatment or rehabilitative services in the public or private services. In many instances, personnel are brought in from outside of the country – on ad hoc as well as more permanent bases; training is also conducted within the specific facility. In these ways, a full complement of high quality personnel is maintained. Since this area is often considered to be on the “periphery” of the health sector, it has not been difficult to provide the complement of services within the frameworks and *modus operandi* of the existing tourist resorts – especially in Tobago.

Recuperative facilities

There is also a relatively new and growing interest in the development of recuperative and convalescence services. Certainly, several interests in the private sector are alert to the potential benefits of linking the traditional hospitality and health sectors in this way. Most think that it would not be difficult to differentiate existing health and tourism services so as to develop comparative advantage in this area. Feasibility would of course, depend on the length of time needed for direct interaction with the more traditional type of health provider, and on the range of what type of services needed for the delivery of a quality service. The implications for the spectrum of therapeutic support and range of

professionals required would then need to be carefully assessed. These have traditionally been in short supply in the Caribbean.

Treatment Services

With respect to treatment and rehabilitative services, experience in other countries [Sidorenko & Findaly 2003; www.canmednet.com] shows, and most key informants agree that success and sustainability in the short and long term are likely to be limited without an appropriate supportive and enabling environment, as well as the presence of good back-up and integrated services.. But if the focus is on the provision of “destination medicine” or out-sourced health products, and if it is to be internationally competitive in terms of level of care, price and service, then good case-management capacities, referral and support services must also be in place. The increasing availability and affordability of the technology infrastructure in support of telemedicine and which can facilitate consultation and diagnosis has meant that national and geographical boundaries and barriers no longer need to impede access to centres of excellence which could provide those kinds of capabilities. In the same vein, remote and/or rural areas may no longer have to be seriously disadvantaged.

Certainly, effective joint local/international partnerships could help to ensure the satisfactory provision of this kind of service; there was great interest in such arrangements, and the government political and infrastructural establishments appeared willing and able to facilitate them. However, successful implementation and longer-term sustainability would require significant levels of government commitment, facilitation, and possible investment; that is, effective public-private sector collaboration. A clear benefit for the public health sector could be that the presence of high quality and state-of-the art facilities in these areas would help to retain skills in the country, as well as help to “pull up” the level and reach of service in the public sector. Certainly, there may be possibilities for using the foreign exchange and private collections to help finance the public health sector. The real challenge – especially if it is to be politically feasible in the longer term- will then be to identify mechanisms – collaborative or otherwise - that would a) prevent the development of a dual and inequitable health system with enclaves of high quality health facilities; and b) foster mutually beneficial linkages between the private and public health sectors, and between state-of the art health services and community health. As Alleyne [2001:8] has noted:

We cannot be insensitive to the criticism that may arise when the services for export are better than what are available to the local population. The answer ...[may be] to create an environment such that there is seen to be some benefit to the local institutions and patients from technology that must be made available.

Alternative Medicine

Alternative complementary medicine represents another area with great potential and in which there is a great deal of interest. Although it is a major growth area – in the Caribbean as well as internationally – it is still very much an unregulated area, and also

straddles the ‘wellness’/‘treatment’ divide. As governments become more interested in exercising some oversight of this area, the ease of entry and development will then depend on which side of the divide a proposed initiative may fall. There is a Caribbean Association of Complementary Medicine whose main objective is to ensure the integration, acceptance and expansion of alternative and complementary medicine. Activities are largely in the areas of promotion and advocacy.

Finally, as the new growth opportunities are explored, the interest in developed countries in outsourcing continues to expand, and the governments’ interest in maximising foreign exchange earnings continues to be almost insatiable, the doors for many new entrants will widen even further. Innovative, careful/rational forward planning at the highest policy levels is then necessary if the countries are to get in on the ground floor, identify possible niches, and grasp the new opportunities in ways that can bring maximum benefit for the countries in the region, even while minimising possibly negative consequences for the domestic health systems. In this regard, the very recent proposal [funded by The Commonwealth Secretariat and supported by CARICOM] to explore the viability and benefits of partnerships between training institutions, host markets, and Caribbean tertiary institutions in the development of training programmes for nurses and teachers could provide useful lessons and ideas about possible strategies and ways forward. This initiative, which is a response to the demand for these two types of professionals in the North America and the UK and the eager responsiveness of the relevant individuals in the sending countries, seeks to develop private/public sector partnerships that will support a managed migration programme, develop the capacity of Caribbean professional training institutions to deal with local and international market demand in these areas, and minimise the drain on the local health and educational sectors.

In general, it would seem necessary to seek to learn from the experiences of earlier “industrialisation by invitation” ventures so as to minimise situations where entry is based only on the tax gains to the government through the payment of fees and rent, and/or to the local community for the provision of ancillary support services, but more so on the potential for mutually beneficial forward and backward linkages, and sustainable development. In this regard, the relevant persons and interests in the public and private health sectors would need more involvement in discussions on trade liberalisation than would now seem to be the case.

Organising for Trade in Health Services: Structures, Options, and Risks

Utilising excess capacities

From the earlier discussion it may be concluded that there is a fair amount of excess capacities in the private health and hospitality sectors which could be more profitably and efficiently used. Indeed, the recognition of this resource underutilisation is helping to fuel the current drive to look for wider and external markets, and to find ways of using that capacity to help service the under-served public health sector. Thus for example, there are new initiatives to revitalise the Eric Williams Medical Services Complex [EWMSC] at

Mount Hope, which had been established about 10 years ago with state-of the art equipment and facilities, and which had been intended to be a central health provider of excellence for the countries in Caribbean region. While some of its facilities (e.g. those in the Hibiscus Suite) function at very high quality levels, significant areas of the complex remain uncommissioned, and it has been estimated that to date only about 30% is utilised. The new efforts, with funds from the government as well as international agencies such as the IADB, to upgrade and/or introduce new services and facilities could then present an important opportunity for initiatives in trade service development. These will include the establishment of state-of-the-art open-heart surgery and trauma facilities. The linkages being established with the University of the West Indies, and institutions in Miami and Bristol indicate the possibilities for using collaborative ventures to both develop local capacities, and to enable eventual competitive participation in wider regional international environments. Then there is the proposed development of a National Oncology Centre. This facility will be introduced through a Government to Government arrangement with the Canadian Commercial Corporation [CCI]. CCI will provide the design, equipment and facility specifications and the development of the care and treatment programme and protocols. Construction is to begin by 2005 and the service is expected to be operation in 2-3 years after that. It will have own its management structure and will be free to purchase in services – locally, regionally or internationally.

An example of an EWMSC initiative to make more productive and innovative use of its resources is the recent agreement with British Petroleum (TT) that established a heliport at the hospital to facilitate emergency evacuation and medical travel into and out of the Complex. This service is expected to be a money earner through fee-for-service arrangements for other companies. In other words, it is more generally conceptualised in terms of the development of an infrastructure that could enable and facilitate the provision of high quality services to the growing oil and off-shore sectors in the region, and of course also to potential clients in the wider regional and international markets. At the present time it is anticipated that if the current bid for the headquarters of the FTAA is successful, then this would significantly expand the possibilities for the supply of high quality destination or off-shore medicine.

There are other health facilities, which fall more clearly into the private health sector – but where there are also new and expanding services that could profitably benefit from increased involvement in a bigger market and greater trade in health services. Several of these new facilities – such as the St. Clair Clinic and the West Shore Clinic - emerged largely in response to the deficiencies and inadequacies in the public health sector. The West Shore Clinic (52-bed capacity, 72 nurses and some 50 doctors) was set up by a group of doctors; it now claims to have the most modern facilities and equipment plus the best skill capabilities in the region for laproscopic surgery. It is currently setting, or planning to set up facilities for vascular, eye and heart surgery; it is also in the process of putting together packages that could be marketed regionally and internationally, in order to ensure the maximum and most efficient use of the existing and planned capacities.

Finally, there is a group of companies under the name of Financial Concepts Ltd, which together provide a very good example of an entrepreneurial health initiative that is

seeking to a) adapt the traditional tourist product in such a way that it captures and operationalises some of the objectives and strategies for preventive health care; and b) develop innovative linkages between private and public sector services. The strategy will be to pull together the financial, construction, business management skills and resources now available within this group of companies into an arrangement that would work closely with the EWMSC to establish an integrated facility that will offer a spa resort (a 25 bungalow facility), a recuperative (25 beds/units) facility, and a treatment urology (offering dialysis and kidney transplant services) centre. Plans include the establishment of linkages with health and wellness services in the public health sector, and the discussions with the government about possible ways of using fiscal incentives to encourage lifestyle changes; here, the goal will be to transform the orientation to spas where they come to be viewed as a necessity vs. mere luxury. There are also innovative ideas and plans about the development of strategies and mechanisms that would enable maximum integration of the surrounding communities into the network of facilities. It is anticipated that successful community involvement would positively contribute to community development in the health and other aspects of community life, and at the same time help to ensure the longer-term survivability of the facilities. In this connection, it is hoped that the new facilities will be able to deliver corporate spa services that would target the existing oil and off-shore markets, as well as provide services for the lower income groups, perhaps by also using incentives and structures created within and through the existing Credit Union system. This initiative is open to involvement in partnerships with joint ventures with foreign business enterprises. It also plans to be evolutionary in the establishment and expansion of the services and facilities, and market driven in the development of the areas of specialisation.

Building on existing institutional infrastructures

At the present time, there is a fair amount of inter-island movement – privately, and through formal government-to-government arrangements - in search of superior health care. In many Caribbean countries there are therefore institutionalised arrangements that that could be adapted for use in an expanded health trade, and through which some benefits from such an expansion could be transferred to the public health sector. The notion of shared health services has been firmly on the health agenda of the CARICOM health community for at least the past 2 decades, and a tradition of co-operation in the health services has emerged. It emerged largely in response to the recognition of the inadequate state of national public health services, but even more importantly, of the reality that none of the countries – at least in the OECS region – were ever likely to have the resources to be fully self-sufficient in the provision of the full range of health services necessary to handle the health demands at country level. Agreements involving the French and English countries in the region have therefore been put in place, especially in respect of secondary and tertiary level services. It is also possible to use a Chief Medical Officer-to-Chief Medical Officer linkage that allows individual access to the services in another country. In addition to these, there are a number of private individual arrangements – usually paid for “out-of-pocket”. At the present time, the EWMSC in Trinidad takes patients mostly from Guyana, Antigua and Grenada,

especially for eye surgery and joint replacement. It has an Overseas Desk specially set up to process and manage in-coming, non-Trinidadian patients. One study [PAHO/OECS 2002] has suggested that residents of the OECS member countries use these mechanisms for approximately 55% of their hospitalisations at the Queen Elizabeth hospital in Barbados, and some 10% of the total hospitalisations at the Centre Hospitalier Universitaire in Guadeloupe are from the English-speaking countries.

However, criteria for patient transfers and cost-coverage differ from country to country, and in general, there is some consensus that the system is both inadequate and inefficient. The problems have led to greater use of individual and private sub-contractual arrangements with services in the private health sector and with the EWMSC. While there would seem to be fair amount of inter-island transfers there are little data on the actual volume of this movement. Any efforts to build on any of these institutional structures already in place would need to be better informed about the carrying capacities of the existing arrangements, and greater specification about what capacities and resources would be needed to service what types and levels of demands. Certainly some streamlining of the transfer system would be required. Even more importantly however, there would need to be discussions and agreements at the regional policy-making levels about the kind of policies and incentive protocols and systems necessary to facilitate efficient and effective regional level co-operation, and which would encourage the most beneficial regional distribution of specialised facilities, and referral systems. Unfortunately, the experience with this more rational approach to regional co-operation has not been spectacular. Nevertheless, it is equally clear that the *de facto* competition among countries offering these services is not likely to be productive nor sustainable in the longer –term.

Incentive and Facilitative Structures

The observation that there are no specific incentives for trading in health services or to stimulate health tourism market – made in 2001 [Gonzalez et al 2001] – is still essentially correct. However, there is now a regional initiative known as PROFIT in the Caribbean (PROINVEST) whose principal objective is to promote partnership and investment opportunities in the tourism industry sector by bringing together enterprises from the Caribbean and Europe. This is organised within the framework of a programme of the ACP Group and the European Commission for the promotion of investment.² There is also The Tourism and Industrial Development Company [TIDCO] which had been set up to be the entry point for foreign investment enquires in Trinidad and Tobago. It was established in 1995 when the assets and liabilities of three former agencies were absorbed and one company set up to encourage the growth of investment, trade and tourism, these companies were - the Industrial Development Corporation, the Export Development Corporation and the Tourism Development Authority. TIDCO includes an Investment Facilitation and an Investment Promotion Department. The former is responsible for the evaluation of applications from investors for industrial and tourism investment incentives

² For more information ,see www.onecaribbean.org; www.ProfitCaribbean.com

final approval lies with the Ministries and assists in processing licenses. The latter is responsible for promoting Trinidad and Tobago as a suitable location and participates in trade fairs and other promotional projects.

The mission of TIDCO is "to market and promote brand T&T", and as such their primary objectives are to be the premier promotion and business facilitation organization in the world, and to establish Trinidad and Tobago as the world's premier destination to invest, conduct business and visit. To this end they strive to understand the needs of the business sector, and work closely with Government and the business community. They also partner with individuals and companies in an effort to help them turn their economic and tourism ideas into feasible activities.³ However, at the present time, it has no specific initiative in the area of health sector development, and some private sector interests do not in fact see the need to solicit their assistance. Similarly, although the Chamber of Commerce welcomes the possibilities for trade in health services, is not currently involved in any advocacy, promotion or the provision of technical assistance in this area. One possible exception may be the current efforts to explore possible collaborative efforts with Cuba.

Nevertheless, there would appear to be few obstacles to the entry and establishment companies interested in trade in health services. Certainly, there is keen interest at the policy-making levels in the government. In addition, there is a fairly flexible, incentive system: tax and duty free concessions, and subsidised interest rates are available; and the concessions are themselves Ministry specific – thereby facilitating negotiation and adaptation to specific needs and circumstances. Also, it is no longer necessary to be licensed to purchase property or invest. The negotiations underway for the establishment of the CSME will allow incorporated entities owned by CARICOM nationals to invest other CARICOM other countries. Only registration would be required. However, there is still a fair amount of intra-regional variation with regard to free access by non-CARICOM nationals. Trinidad and Tobago is perhaps the most open, and in the health and tourist sectors there are no limitations on market access or on national treatment [CSME Country Briefs, 2004]. A note of caution may however be introduced here; there are differing opinions about the user-friendly character of the existing arrangements with opinions ranging from which find entry and facilitation relatively easy to those which bemoan the extent of the bureaucratic red-tape and the tardiness of the system, and which emphasise the necessity for personalised contacts. Development and expansion of trade in health services would therefore seem to require more streamlined, transparent and institutionalised structures and systems, and less dependence on informal networks. There is need to bring the current variations in the incentive arrangements and rules of engagement into a single and more coherent economic space.

³ Sources the TIDCO website : www.tidco.co.tt and The Caribbean Export Development Agency Trinidad and Tobago Country Brief Report, June 2004

Regulation and accreditation

Currently, there is on-going work to put in place adequate quality control standards. In 2002, a Patient's Charter of Rights and Obligations was agreed on and published. At the moment licensees for hospitals, doctors, and nurses are granted by the relevant Boards. However, the government has been working with the Joint Commission International [JCI] to establish a single streamlined system for the accreditation of all private and public health care facilities – including laboratories, diagnostic centres, outpatient clinics and day surgery centres. In 2002 a comprehensive Standard Manual for the Health Sector was published. When fully operational the programme will be managed under a statutory body; the government will however retain responsibility for the system of licensing of private facilities. There is also a new Health Quality Assurance Act coming; final drafts are still under discussion. When finalised it will be geared towards the better enforcement of standards, as well as the screening and *ad hoc* assessments of services and facilities; attendance at up-grade seminars will be required. Critical to the effectiveness of this initiative will be the capacity of the government to enforce the guidelines and standards.

Regional Health Authorities have been established to facilitate the more efficient management of the health system through the decentralisation of operational management. Health Reform discussions are still on-going, as the government seeks to arrive at final decisions about how to make the services more responsive to consumer needs and preferences and to bring health decision-making close to those actually providing the services. The thrust of the recommendations currently under consideration would strengthen the split between purchasers and providers, and seek to target health financing to the explicit identification of health care needs. The Ministry of Health would retain the overall policy-making, monitoring and regulatory functions. Under this system the Ministry would “actively promote the sub-contracting of services, and regions would be free to acquire services from wherever, they can obtain the best combination of quality and cost – for equipment maintenance and supplies, for example as well as for clinical services from independent physicians and others” [Health & Life Sciences Partnership, 2003:5]. One possible advantage of such system is likely to be that the inefficiencies and inequities in the current public-private mix in health could perhaps be effectively addressed. Another is that it could facilitate the entry of externally-based private health services. In the case of the EWMSC it would, for example, become owned by a regional health authority it would be able to exercise authority and autonomy in how it may wish to best position itself in an emerging market surrounding health trade. In so far as this model is based on that implemented in the UK National health system, it would then have to find ways to avoid some of the undesired consequences that have threatened the equitable functioning of that system. There the *de facto* introduction of an element of privatisation and market principles increased the likelihood of greater inequities in the delivery of quality health care.

Health Care Finance and Provision

There are at least two possible constraints or risks that could affect the feasibility or potential for growth in health trade. One has to do with the stable availability of human resources, the other with the non-portability of health insurance. With respect to the first issue the most recent review of the health conditions in the Americas [PAHO 2002: Vol. N: 522] noted that the

distribution of human resources in health between primary and secondary care is a concern, as is the shortage of staff in general....Emigration and retirement of staff have left a large void ...and have forced the government and regional Health Authorities to recruit staff from abroad and rehire retired nurses. Estimates suggest that there were 18.9 professional nurses per 10,000 population in 1999, compared to 16.9 in 1992, and 7.5 physicians in 1997, compared to 9.0 in 1992.

In 1999 the ratios for nurses had improved as it moved to 28.7. However, that for Doctors remained at 7.5 [PAHO, 2002: Vol. 1: 381]⁴.

Turning to the latter issue, this would be especially important for those types of health care normally covered by insurance policies.⁵ Whereas in 2001, there had been fears that this would have presented an “insuperable hurdle” [Alleyne 2001:8], discussions with key informants in the insurance and care management organisations suggest that this may no longer be the case. Most of the major insurance companies in the region now operate at the regional level; handling intra-regional movement for health care therefore presents few difficulties. There are also insurance coverage packages that allow Caribbean residents to obtain health care outside of the region – on an emergency basis, or if it is not available within the region, or if the client prefers to get the service outside of the region. In the last-mentioned situation however, reimbursements would be tied to local costs for the equivalent service/care.

For persons coming in for a health service there are a number of possibilities: first of all, persons normally resident outside of the region can usually obtain and pay for emergency care within the region. There would appear to be little difficulty in obtaining reimbursement for the cash paid at the point of service. For non-emergency care there would seem to be a number of possibilities: one is that a specific package (similar to that under existing travel insurance programmes) could be purchased for use in the country (or countries) to which travelled; another is the use of “preferred provider networks”. This appears to be an important growth area as companies increasingly recognise the need to adapt the enabling and support services to the changing and liberalising international environments. Many are also anxious to find innovative ways to

⁴ Comparable figures for countries in the region with relatively similar GDP per capita even though with smaller populations are: St. Kitts-Nevis, 11.7 (for physicians) and 49.8 (for nurses); Antigua, 11.5 (for physicians) and 32.2 (for nurses).

⁵ Since most cosmetic surgeries, spas and body health programmes are not normally covered by health insurance the issue may not arise.

differentiate the insurance product. From the patient's perspective it can allow them access to preferential prices.

The services currently offered by the Canadian Medical Network/Care Management Network⁶ provide an illustration of the possibilities for care management across international borders. This network (now in existence for about 10 years) enters into contractual arrangements with governments, insurance companies, physicians, specialists and hospitals in more than 130 countries and seeks to advocate, facilitate and manage health care for the international patient. The main services include

- § medical care management: reviews of medical necessity, pre-certification of care, selection of providers, the co-ordination of admissions, and monitoring of treatment plans;
- § claims management, processing and negotiation;
- § logistical assistance for transportation and accommodation; and
- § emergency care coverage.

At the present time, they are still largely concentrated in the North American and UK markets; their proprietary network in the US consists of over 7,000 acute hospitals, and more than 400,000 physicians and specialists. However, the Network is in the process expanding its presence in the Caribbean and is for example, now entering into contracts with the EWMSC as well as a number of private sector facilities in a number of countries including Trinidad and Tobago, and Barbados. The successful operation of these kinds of international networks will, at least in part, depend on the smoothness and user-friendliness of the administrative processes.

Another option – especially for those working in the offshore sectors is the provision of a “third country product”. Thus for example, local insurance companies now enter contractual arrangements with foreign companies so that a foreign national working in the local subsidiary (offshore or otherwise) would have insurance coverage for services received within the region. At the present time, this type of coverage is available to only a small and selected group of persons, but it does present a possible model for further exploration.

Certainly, it does not now seem feasible for local/regional insurance companies to directly offer services in foreign countries or coverage to foreign nationals. Registration is mandatory, costly and onerous; and there are fears about untenable exposure to litigation in an international environment. However, it needs to be borne in mind that insurance companies are normally re-insured with major international ones; enterprises (especially joint ventures) that could offer health services that are internationally quality, and price/cost competitive would, in all probability, find receptive ears and a willingness to explore the options.

⁶ Information gained from telephone interviews with local and Canada-based managers and from their web-site:- www.canmednet.com

Finally on this point, the Caribbean Tourist Organisation is currently involved in negotiations under GATS to include the issue of health insurance portability in the discussions about the liberalisation and development of health tourism.

The problem of internal inequalities

Health tourism and trade would in all likelihood be largely a private sector initiative, involving the careful crafting of appropriate fee-structures. Fee structures however mean that services would normally be limited to those with health insurance (a relatively small but growing sector in the region) and/or at the higher end of the income scale. This immediately re-introduces the challenge of finding ways to ensure that increasing marketisation and privatisation of health do not induce internal inequalities. In this regard, the current health reform proposals that would permit the purchase of services by regional health authorities proposals, as well as the new plans for the implementation of a national health insurance scheme that aims to provide coverage for a package of services could facilitate the development of mechanisms that could improve access to quality care by the more disadvantaged sectors of the society. Indeed, at the present time, the Private Hospital Association [PHIA] is in negotiation with government to implement an arrangement whereby some of the excess capacity in the private hospitals will be used to clear some of the backlogs in specific areas (for example, urology, and cataract, hernia, and prostate surgery), and at the government's expense.

Other support services

Earlier, it was noted that the successful and sustainable provision of medical treatment, and some aspects wellness and recuperation services would require access to good integrated back-up systems. One important linkage would be the laboratory and disease surveillance systems. In this regard, The Caribbean Epidemiology Centre provides the following services:

- š Reference and referral in Microbiology and Medical Entomology,
- š Training and appropriate research for surveillance and control of Communicable Diseases.
- š Assistance in communicable disease outbreak investigations, emergency disaster response, information systems development and improvements, etc.;
- š Dissemination of technical information through publications and scientific conferences;
- š Training in Epidemiology, health statistics and computer applications;
- š Conduct of epidemiological research e.g. HIV risk factors, KAPB (Knowledge, Attitudes, Practices and Beliefs) studies on cholera;
- š Developing norms, plans and policies for Infection Control and recommendations for immunisation guidelines

Within its mandate to promote and strengthen the maintenance of high standards, by early 2005 the Centre will have established a hotel surveillance programme which seeks to strengthen the "overall quality and competitiveness of the tourism industry in the

Caribbean through the establishment and promotion of quality standards and systems designed to ensure healthy, safe and environmentally conscious products and services” [www.carec.org]. The Centre is also in discussions with a USA-based company to provide a regional information system that would permit better tracking of disease, and on-line information about standards. It also wishes to link with North American institutions for “just-in-time” training also using distance education, and electronic portals.

Human Resource availability

This has traditionally been a fairly significant constraint in the Caribbean region. There are now systems in place for the standardised training of nurses and physicians – thereby removing one barrier to the deployment of skills in different countries within the region. There is a fairly strong political commitment to the achievement of freedom of movement for skilled labour – especially within the developing frameworks of the Caribbean Single Market Economy [CSME]. Although a number of “kinks” which hinder perfectly smooth movement still need to be ironed out there has been significant improvement in this area. However, there continue to be fairly serious bottlenecks in terms of the quantum and range of skill-types available. Medical specialists as well as some of the skills (for example, for pain management treatments, acupuncture, auyvedic treatments) that would be required in a facility that offers sophisticated body health services are in very short supply, and must often be imported. Even more important is the limited local absorptive capacity for the numbers trained. There is a serious brain-drain of nurses and physicians to the developed countries; this outward migration is also not helped by the current limitation of the retirement to 60 yrs: administrative personnel at the EWMSC complex for example, argue that this creates a bias against the more experienced persons who by the age of 55 years often begin to explore other options abroad.

One strategy to alleviate the human resource shortages has been the importation of skills on a short-term basis (as is the case with physicians and nurses from Cuba), or on a longer-term basis. But there is also some leakage here, as some use this as an avenue for entry to North America. Another is the proposal for managed migration discussed earlier. A third is to encourage the training of a wider range of skills through telemedicine linkages with schools and centres of excellence in developed countries. Such a linkage could also enable access to training and diagnostic skills and resources not otherwise available locally. One very important expectation of increased trade in health services therefore is that through the increased opportunities locally and regionally, it would encourage and facilitate a greater retention of skills in the region.

West Shore is actively recruiting specialists and qualified practitioners who want to return to work in their home country and have the benefits of a rewarding professional environment.

B. ST LUCIA

The economy of St Lucia saw signs of recovery in the year 2003 when real output growth was estimated at 2.0%. From 1980-2000 the economic performance was characterised by distinct periods of peaks and troughs. However, by the end of the century St. Lucia had experienced a decade of uninterrupted growth – growing at an average of 2.6% annually. In 2001 the economy declined by 4.5%, but by the end of 2002 – with real growth estimated at 0.2% - there were signs of recovery. Growth in the economy is largely due to developments in the service sector – and in particular, the tourist sector. The data in Table 1 show that by 2003, the service sector accounted for 85% of GDP. In 2003, Hotels and Restaurants grew by almost 10%, and with its contribution of approximately 14% is now the single largest sector. A reduction in concessionary aid inflows, together with the decline in the banana industry that resulted from the erosion of the preferential treatment for bananas had contributed to the poor performance of the economy during 1993 to 1997. The more recent expansion of the service sector has therefore meant that the structure of the economy has been significantly transformed; it is now a service-based *versus* primary-commodity based economy.

Table SL: Sectoral Distribution of Current GDP (%)

| Sector | 1999 | 2000 | 2001 | 2002 | 2003 |
|----------------------------------|------|------|------|------|------|
| Agriculture | 7.5 | 7.4 | 6.8 | 6.4 | 5.4 |
| Mining and Quarrying | 0.4 | 0.5 | 0.4 | 0.4 | 0.4 |
| Manufacturing | 5.6 | 5.1 | 4.9 | 4.8 | 5.0 |
| Utilities | 5.1 | 5.6 | 5.9 | 5.5 | 5.4 |
| Construction | 9.0 | 8.4 | 8.3 | 7.8 | 7.3 |
| Hotels and Restaurants | 13.2 | 13.8 | 12.9 | 12.7 | 13.6 |
| All Other Services ^{a)} | 67 | 67.3 | 69.1 | 70.8 | 71.4 |

Source: Caribbean Development Bank. Social and Economic Indicators. 2003. Vol XIV

NB: The columns will not add up to 100% as the contributions of “Imputed Services Charges” and Values Added Tax have not been included in the table.

- a) This category includes Transport and Communication, Financial and Business Services, Government Services, Wholesale and Retail Trade, Other services.

St Lucia has always been promoted as a tourist destination, and it is now widely promoted as the major health tourism destination, or more specifically as the “Spa Resort Destination” of the Caribbean. According to the Director of Tourism, weddings/honeymoons account for 36% of St Lucia’s tourism, with a growing family market.

Table SL2: Air and Cruise Ship Arrivals, and expenditure levels, according to destination

| Country | Tourist arrivals 2003 ^{a)} ('000s) | Cruise Ship arrivals - 2003 ('000s) | Ratio of Visitor Expend. To Merchandise Exports ^{a)} | Contribution to GDP ^{a)} % | Expenditure per capita ^{a)} (US\$) |
|-------------------|---|-------------------------------------|---|-------------------------------------|---|
| Antigua | 224.0 | 385.7 | 6.9 | 63.4 | 4,054 |
| Barbados | 531.2 | 559.1 | 2.6 | 33.0 | 2,659 |
| Jamaica | 1,350.3 | 1,132.6 | 1.0 | 21.3 | 1,774 |
| St. Lucia | 276.9 | 393.3 | 5.1 | 63.8 | 1,774 |
| The Bahamas | 1,428.6 | 2,970.2 | 4.6 | 44.0 | 5,948 |
| Trinidad & Tobago | 408.3 | 55.5 | 0.08 | 3.6 | 164 |

a) 2000 data.

Sources: Caribbean Tourism Organization; Statistical Office of St Lucia; St Lucia Tourist Board

From the data in Table 2 above, the importance of Tourism in the St. Lucian economy is further illustrated. Tourists now come for a variety of reasons. One of the major markets/activities for St Lucia is that of recreational diving. The largest portion of tourist

Table SL3: Tourist Arrivals, by Markets, Jan – May 2004

arrival are from the US, UK and Caribbean markets with the largest one being the US market [Table 3].

| Markets | 2004 | % | 2003 | % |
|----------------|----------------|------------|----------------|------------|
| USA | 46,150 | 36 | 44,213 | 36 |
| UK | 37,290 | 29 | 32,247 | 26 |
| Caribbean | 26,854 | 22 | 28,752 | 23.3 |
| Canada | 8,906 | 7 | 8,025 | 6 |
| Rest of Europe | 2,575 | 2 | 2,892 | 2.3 |
| Germany | 1,534 | 1 | 2,080 | 1.7 |
| France | 4,024 | 2 | 2,437 | 2 |
| Rest of World | 1,269 | 1 | 2,911 | 2.4 |
| Total | 128,602 | 100 | 123,557 | 100 |

Note: Rest of Europe - Holland, Italy, Austria, Belgium, Denmark, Greece, Ireland, Luxembourg, Norway, Portugal, Spain, Sweden, Switzerland

Opportunities for Trade in Health Services: Defining Comparative Advantage

In discussions with key individuals both in the public and private sectors, it was clear that interest and appreciation of its potential is very high. It is still nevertheless an insufficiently exploited area, and there is the need to take what is presently being done in relation to wellness tourism and expand it to incorporate other services. There is a sharp perception that given the small size of the surrounding environments and the available or likely resource base/potential St. Lucia could not easily compete with the larger tourist destinations – including those within the Caribbean region. It must therefore focus on the provision of a high quality product for niche markets and which is most probably targeted at the upper end of the income scale. At present, the government of St Lucia has allocated funds for a consultant, in conjunction with the European Development Fund, to conduct a feasibility study on St Lucia and the potential to embark on health tourism. The objective of the study will be to determine the potential of a sustainable health tourism sector as a diversification of the existing tourism industry, in a manner, and which is consistent with the economic development of St Lucia. More specifically, the consultant would have to evaluate the potential of health tourism and determine the activities that can provide the best benefit to the St Lucian economy and are the most attractive to national and international investors.

Although there has not been substantial activity in the promotion of trade in health services there are several perceived benefits for St Lucia. These include:

1. Economic benefits such as foreign exchange earnings;
2. Increased employment opportunities for all types of personnel who will gain employment in the sector as more jobs become available;
3. Improved treatment as local medical personnel would have to bring their skills on par with those being offered by the specialists who would be brought in to perform various tasks; and
4. Advertising other tourism products, so that St Lucia develops a reputation on the international map as a tourist destination that offers more than the typical “sun, sea and sand” holiday.

The potential of St Lucia for embarking on this development path and also to attract investors willing to become involved in trade in health services is likely to be moulded by at least four distinct considerations:

- ∓ The quality of the telecommunications infrastructure.
- ∓ The country’s comparative advantage in respect of the environment, climate conditions and the variety of wellness spas that already exist. Clients from the international market who would be seeking a warm and comfortable atmosphere/environment to recuperate or convalesce would find that St Lucia is an ideal place for this.
- ∓ Medicinal foods: St. Lucia once had a vibrant agricultural sector that could be linked into the tourist sector through the provision of local foods and herbs –

especially for those seeking to recuperate and to generally pursue a healthier way of life while in vacation.

- € The lower cost of living that could enable the provision of particular medical services at cheaper and competitive rates than would otherwise be afforded them at home. Services such as cosmetic surgery could be made into a holiday package where clients could travel to St Lucia, have their surgery, recuperate and enjoy a sun, sea and sand vacation within one package.

At the present time the following activities [See Table 4] appear possible, and/or are actively being contemplated:

Table SL4: List of Products being ‘traded’, or in which there is active interest – St Lucia

| Wellness | Treatment | Rehabilitation |
|---------------------------------------|---|--|
| Spas Lifestyle/body health | Elective surgery Oncology | Renal Dialysis Recuperation, convalescence, and recovery; |
| Alternative Complementary Medicine | Orthopedics Cardiology Plastic/cosmetic surgery | Drug and alcohol rehabilitation |

Although there is great interest in trade in health tourism there is nonetheless awareness that efforts in this direction would have to be circumscribed and restricted to wellness types of activities, at least until the local health facilities are upgraded and are able to offer a higher quality service. Many persons felt that there are numerous opportunities for offering medical services in the area of cosmetic surgery. Though considered viable, it is however, not being embarked upon with the energy being put into the development of other services. In terms of general medical services, these cannot be developed immediately due to the several constraints being faced within the health sector. The government is however in the process of constructing a new hospital, which is slated to be completed in the year 2007, and which is expected to be self-sustainable. There will also be new mental health facility. There are also plans to transform the District hospitals so that they instead function as well-equipped polyclinics. Polyclinics now located within the “tourist belt” - and which are in fact now used by tourists - will then be able to provide a superior and perhaps more differentiated service. St Lucia has made a few small steps so far in the areas of kidney dialysis and CAT scans - although on a small scale.

In St Lucia there are two public hospitals, the Victoria Hospital and St Jude’s Hospital that has recently been refurbished. St. Jude Hospital is a 110-bed facility that has medical, surgical, maternity and paediatric wards, two operating rooms, recovery room, intensive care, emergency room, pharmacy, laboratory, x-ray, ultrasound and physical therapy. In 1998, the hospital admitted 4,851 patients, recorded 932 live births and conducted 1,025 operative procedures. There was a total of 31,452 outpatient visits.

Outpatient clinics include general medical and maxillo facial facilities. Specialty clinics for General Surgery, Orthopaedics, ENT, OB-GYN, Dermatology, Cardiology, Rheumatology, Internal Medicine, Paediatrics, Diabetic and Psychiatric Care are also held regularly. St. Jude's provides high-quality primary care for the largely rural southern half of the island but its specialty care services the entire island. The hospital employs about 200 local staff, including 14 full-time physicians. Volunteers play an important role in augmenting the permanent staff.

The St Jude Hospital is partly government funded and partly funded by patients paying up-front (in advance) for each item of service and consultation that they receive. Many patients do not pay for these services (eg 'paupers', government workers, hospital workers, police, prisoners).

The government of St. Lucia is amenable to the establishment of a joint partnership between itself and providers of health, such as pharmaceutical companies. There is openness to negotiations with foreign providers where these providers can provide cheaper drugs or cheaper services to the locals of St. Lucia or provide assistance in the local hospitals. This would be provided in return for guaranteed markets for these cheaper drugs or access to some other economic benefit. Even so, there would seem to be some consensus that increased trade in health services would have to be mainly a private sector activity. The main role of the government would be facilitative, enabling, and regulatory.

Wellness and healthy life-style services

The great interest in St Lucia in the promotion of “wellness” products is also due to the fact that hotels are anxious to find ways to differentiate their product in a very competitive market environment. At present St Lucia is promoted as the ideal location for a spa holiday. Wellness and healthy lifestyles is the main focus of the package that is offered with the spa vacation, and a variety of services (e.g. nutrition and healthy eating programmes, acupuncture, Reiki, ayurvedic treatment) are now offered. The various kinds of personnel that would be required for the various types of services and therapies and healthy lifestyle programs that are being sought are already in place. Personnel have either been brought in from abroad, or recruited from within St Lucia and given additional training. One such resort (Le Sport) that makes healthy living a main focus in its spa vacation package is the Sun Swept Resorts, which possess one of the world's acclaimed health spas, the Le Sport. Advertised as a location for “a body holiday” – it is currently owned by Sun Swept Resorts- a company that has facilities in the USA, Canada, UK and Europe⁷. In St. Lucia, it is located on what was a large coconut estate and family owned. Malabar Beach Hotel was first built there, but over the years the hotel grew, and in 1983 the Barnard family took out a franchise and the hotel became Couples St. Lucia. In 1993, this franchise ended and the resort reverted to the direct leadership of the family, and the current facility – now known as “Rendezvous, the Escape for Romantics” was established. At the present time, it has 154 rooms and suites and advertises itself as a complete spa that provides the “first holiday in the world to combine a great beach vacation with the pleasure or personalised rejuvenation...” Its motto is

⁷ See website address: <http://www.bodyholiday.com> .

“give us your body for a week and we’ll give you back your mind” – and it offers yoga, tai chi, meditation, aerobics, stress management, fitness with personal trainers, stress and tone classes, aromatherapy, hydrotherapy, Thalso wraps, a variety of massages, Shiatsu, Ayurvedic treatments, Acupuncture and Acupressure, Reflexology, and a specialist skin clinic. Their fitness facilities include cardiovascular equipment. They largely cater to couples, but the newest accommodations have dedicated single rooms “designed for those travelling alone.” It is therefore a destination spa where persons go specifically for wellness, health of the mind and body, fitness and adjustment. Le Sport is a utility or resort spa where pampering, health fitness and relaxation (through tai chi and yoga) are taken to the highest level. It has the element of a resort spa in addition to health and well being. Visitors also consist of persons seeking great holiday/spa treatment but needing consultations such as dieticians. The spa is also in the market for persons seeking to recuperate.

Alternative/Complementary Medicine

Alternative/complementary medicine is another area within St Lucia that offers great potential for the development of trade in health services. Although it is an unregulated area at present, it nevertheless offers an opportunity, as this is a significant growth industry in St. Lucia no doubt aided by the fact that St. Lucia already has an agricultural infrastructure that can support the production of medicinal foods and herbs. The government of St Lucia recognizes the importance of incorporating the use of complementary medicine in any initiative that seeks to embark and expand a market for trade in health services. One of the leading complementary medicine practitioners in St Lucia has argued that St Lucia is well equipped to embark on this type of trade in health services. There is at least one facility that currently makes its own herbs, soaps, baths and herbal drinks and exports to the US Virgin Islands, St Vincent and a few other Caribbean islands.

Recuperative and Convalescent Facilities

There is also an active interest within St Lucia in the development of recuperative and convalescent facilities. Many private sector entities have realized the benefits to be garnered from amalgamating the traditional hospitality and health sectors to promote convalescence and recuperation. Careful consideration would however have to be given to the types of recuperation encouraged as it would be necessary to ensure that there are adequate back up medical services and skills. The current owners and managers of the Tapion hospital are currently considering the possibilities for establishing - in conjunction with the Pain Management Institute - a senior citizens resort, where travellers can come to St Lucia on holiday with the knowledge that if they for some reason may fall ill, their needs will be met in an adequate fashion.

Treatment and Rehabilitative Services

There was an active interest in developing services that offered renal dialysis, and also in developing and promoting the environment around the Soufriere volcano for its therapeutic qualities. A more controversial area was that related to the development of

substance abuse initiatives within St Lucia, as an area for health tourism. There are strong views within the government that this would not “set good morals for the society”. Activities should instead focus on supporting the efforts of the existing substance abuse committees to reduce the levels of substance abuse in the country.

Organising for Trade in Health Services: Structures, Options, and Risks

Utilizing capacities more effectively and efficiently

Although there is the interest in embarking on trade in health and health related services, the situation in the public health sector does not as yet easily facilitate this. In the case of the Victoria Hospital, one of the two public hospitals in St Lucia, they are barely able to meet the local needs of the populace and are experiencing tremendous problems with their infrastructure, equipment and personnel. An emergency health system also needs to be put in place to adequately deal with crisis and traumatic situations. At the same time, although St. Lucia participates in shared services arrangements with, for example, the French islands in the region, the transfer and financial arrangements are not considered satisfactory or adequate. As already noted, the government does recognise the extent of the deficiencies within the health sector and it is presently in the process of constructing a new general hospital, and transforming the current district hospitals.

Nevertheless, there are other health facilities, which fall more clearly into the private health sector – and where there are new and expanding services that could profitably benefit from increased involvement in a bigger market and greater trade in health services. One such facility is the Tapion Hospital; it is a 32-bed inpatient facility with many specialist clinic facilities, Laboratory, Radiology, Pharmacy Service and Restaurant that was set up by a group of doctors who were frustrated with the conditions of the Victoria Hospital. The original aim of the partners was to make Tapion the hub of medical services in the OECS. Tapion is known for its orthopaedics service that has taken off in recent years and for its strength in cardiology services. Although Tapion has a dialysis unit, it is highly under-utilized since the number of persons accessing the service from within St Lucia is not sufficient. The Board of Directors of the Tapion Hospital, however, are presently considering dialysis as an avenue to health tourism. They are also seeking to promote radiotherapy, cardiology, and the construction of a hyperbaric chamber.

Building on existing institutional infrastructures

Presently, there is some amount of inter-island movement – privately, and through formal government-to-government arrangements - in search of superior health care. In many Caribbean countries there are therefore institutionalised arrangements that could be adapted for use in an expanded health trade, and though which some benefits from such an expansion could be transferred to the public health sector. The notion of shared health services has been firmly on the health agenda of the CARICOM health community for at least the past two decades, and a tradition of co-operation in the health services has emerged. It emerged largely in response to the recognition of the inadequate state of

national public health services, but even more importantly, of the reality that none of the countries – at least in the OECS region – were ever likely to have the resources to be fully self-sufficient in the provision of the full range of health services necessary to handle the health demands at country level. Agreements involving the French and English countries in the region have therefore been put in place - especially in respect of secondary and tertiary level services. A number of private individual arrangements – usually paid for “out-of-pocket” by the patient, are in operation. At present, the Tapion Hospital takes 15% of its patients mostly from St Maarten, St Croix and the US Virgin Islands, especially for cardiology and dialysis services/treatments. These patients are mainly aware of Tapion through word-of-mouth. The majority of the patients are on an emergency basis and may also be cruise ship passengers who fall ill while travelling; some patients are also referred to Tapion through the hotels they may be occupying. With respect to the Victoria Hospital, all tertiary level care is sent to Martinique. There currently exists a bi-lateral technical cooperation agreement between the Victoria Hospital and LaMaynard Hospital where cardiology, neurology and oncology services are provided. One study [PAHO/OECS 2002] has suggested that residents of the OECS member countries use these mechanisms for approximately 55% of their hospitalisations at the Queen Elizabeth hospital in Barbados, and some 10% of the total hospitalisations at the Centre Hospitalier Universitaire in Guadeloupe are from the English-speaking countries. The government would perhaps welcome the expansion of the shared service arrangements, but for it to be incorporated into or linked with any initiatives in health tourism the modalities and strategies would require discussion and agreement at the highest regional policy-making levels.

Incentive and Facilitative Structures

St Lucia’s investment policy aims to encourage investment in the tourism sector. The Government is committed to increasing foreign currency/earnings, diversifying the economic base of the island and creating new job opportunities. The Ministry of Tourism is responsible for policy formulation and The St. Lucia Tourist Board is in charge of advertising, promoting, and marketing tourism activities. Under the Tourism Incentives Act, 1996, a range of both tax and non-tax incentives is offered. Approved tourism products are eligible for these incentives. To receive tax exemptions, a potential investor must have approval by Cabinet following an application in writing made to the Minister. These tax exemptions range from: Tax Holidays/Exemptions, Earnings (Exempt from Income Tax) to Customs Duty Exemptions⁸.

Although this enabling environment may exist in relation to general development in the tourism sector, there is still the need for concentration in tourism where health and health trade is concerned. There does appear to be some flexibility; in the health sector: there are tax and duty free concessions, and subsidised interest rates are available; the concessions are themselves Ministry specific – thereby facilitating negotiation and

⁸ Caribbean Export Development Agency. Caribbean Community Secretariat Saint Lucia Country Brief May 2004.

adaptation to specific needs and circumstances. Government would need to decide which concessions would be made available to those embarking on health trade.

Regulation and accreditation

The Ministry of Health, under the leadership of the Minister of Health, assumes direct control of the public health system and regulates the private system through the Public Health Act (1975). Policy-making, the supervision and control of health services delivery in the public sector is within the purview of the Permanent Secretary of the Ministry of Health. The Chief Medical Officer and the Health Planning Unit bears responsibility for evaluation of health services delivery in the public sector. Intersectoral actions and programs are promoted through the granting of concessions to private sector health care providers, and the collaboration with other Ministries and quasi-government agencies in health promotion activities. Reliable and up-to-date information systems on the health situation and the delivery of primary health care services are available at the Ministry of Health, and the information from these systems is used in decision-making processes. Information systems pertaining to the delivery of secondary care are however outdated and inadequate, and hence, reliable information relating to secondary care is not readily available for decision-making. Information systems on health financing (public and private) are designed for accounting purposes and not tailored to meet health planning or programming needs. Information systems for insurance are limited to the purposes of the individual providers in the private sector; health insurance is usually regarded as a subset of a wider insurance package.

Policy formulation, for human resources and other health issues, is the responsibility of the Policy Committee within the Ministry of Health. The committee comprises core departmental heads of the Ministry. A Monitoring and Evaluation Committee has been established by the cabinet of Ministers for accreditation of medical institutions of learning, based on the Liaison Committee on Medical Education (LCME) of the Department of Education of the USA. Although no formal procedures are in place for the evaluation and accreditation of health facilities, the office of the Chief Medical Officer is required to perform these functions under the Public Health Act. There are no public or private agencies responsible for evaluating health technology. The Medical Council has established standards of clinical practice. The government of St Lucia is in the process of introducing the Medical Complaints Act to regulate clinical practice.

No fully operational Quality program exists in health establishments, the Saint Lucia Medical and Dental Association oversees medical and dental practice through its Ethics Committee. There are no fully functioning committees on hospital infections in hospitals.

At present there is no local accreditation body within St Lucia where standards and protocols of hospitals and clinics is concerned. There is then general consensus that if St Lucia is to embark in trade in health services there will have to be a determination of a set of standards of practice and accreditation whereby medical personnel can be monitored and quality assured. The health legislation would also need to be changed as it is considered outdated and not always relevant nor appropriate. There is at present no good licensing system, and government recognises that if health trade is to be accommodated

the framework would need to be changed. The registration process of medical and health professionals would also need to be reviewed and restated. The Hospital Management Act and a Public Health Act need to be reviewed as a matter of urgency. It should also be noted that the fee structure for medical services would need to be changed. At the present time, it seems clear that questions having to do with what would be a realistic, competitive and appropriate fee structure needs to be explored and addressed. This review would need to be carried out within the framework of the changes now being proposed and implemented in respect of hospital management. The most significant change being considered is that which seeks to split the traditional fusion of the health provider and health purchaser functions. If and when implemented governments would purchase health services, and focus its resources on regulating, monitoring and policy-making functions. At the same time, all public sector hospitals would become statutory bodies. These changes would have no doubt have significant implications for the fee structures and how these are to be determined.

In all of this there is the challenge of insufficient human resources: although significant changes are being contemplated, it will still be necessary to address the problem of marshalling and mobilising the human resource capacity to enforce and manage the changes being made.

There is also the St Lucia National Development Corporation established in 1971 to promote the economic development of St Lucia. This organization functions as an investment, trade and export promotion agency, providing a range of business oriented services to the public, including inter alia; attracting foreign investment to St Lucia, sourcing technical assistance for business sized enterprises, promoting locally manufactured products through regional and international trade missions and exhibitions, identifying sites for hotel development.

A number of priority investment areas in the services sector have been identified. An important priority area is tourism, or more specifically - Hotel/Resort Development. This would then involve:

- € The construction of hotels, resorts, villas, cottages etc for tourism purposes; of which tourism is one
- € The development and marketing of Nature Heritage Sites;
- € The introduction of new attractions for visitors, such as tours of the rain forest and nature trails to market St Lucia as an eco-tourism destination;
- € The establishment of entertainment and leisure centres;

There exist however, some general restrictive provisions. These are described in Table SL5 below (see also Table 2, p.5).

Table SL5: General Restrictive Provisions

| SERVICE AFFECTED | RESTRICTING PROVISION |
|-------------------------|--|
| All Services | Under the Alien (Licensing) Act, 2002, aliens have to apply to cabinet for a license to hold land. No person shall make a payment to or for the credit of a person outside the scheduled territories nor on behalf a person outside of the scheduled territories except with the permission of the treasurer. |
| Work Permits | Work permits required for services not covered under the Caribbean Skilled nationals Act. |
| Company registration | Under the Companies Act, No. 19 of 1996, external companies must be register to carry on a business in St. Lucia. Powers or activities can be restricted by the Registrar. |

Source: Caribbean Community Secretariat. Schedule of Legislative Action Required by Member States, 2004

As St. Lucia continues to implement its programme for the removal of restrictions as scheduled, the range of potential investment opportunities will eventually be expanded further. Although there is great potential for trade in health services, it is nevertheless agreed that St Lucia would be faced with a number of challenges. Some these are:

- ∓ Obtaining the initial start-up costs needed to strategize properly, plan, and develop a quality product. Major investments in plant and equipment or the upgrading of facilities would be needed if treatment facilities were to be considered;
- ∓ Having the working capital to meet the ongoing recurrent costs necessary for longer-term sustainability. ;
- ∓ Developing the capacities for a vigorous marketing drive to showcase St Lucia as the place to come for medical treatment;
- ∓ Being able to provide the range of services to make the venture feasible;
- ∓ Establishing a system that could deal with any legal liabilities associated with treating international patients such as malpractice insurance. Any legislation that would be put in place must guarantee a framework to make sure that any legal issues are settled locally

Health Care Finance and Provision

The other constraint relates to the non-portability of health insurance. This constraint would be especially important for those types of health care normally covered by insurance policies.⁹ Whereas in 2001, there had been fears that this would have presented an “insuperable hurdle” [Alleyne 2001:8], discussions with key informants in the

⁹ Since most cosmetic surgeries, spas and body health programmes are not normally covered by health insurance the issue does not arise.

insurance and care management organizations suggest that this may no longer be the case. Most of the major insurance companies in the region now operate at the regional level; handling intra-regional movement for health care therefore presents few difficulties. There are also insurance coverage packages that allow Caribbean residents to obtain health care outside of the region – on an emergency basis, or if it is not available within the region, or if the client prefers to get the service outside of the region. In the last-mentioned situation however, reimbursements would be tied to local costs for the equivalent service/care.

For persons coming in for a health service there are a number of possibilities: first of all, persons normally resident outside of the region can usually obtain and pay for emergency care within the region. There would appear to be little difficulty in obtaining reimbursement for the cash paid at the point of service. For non-emergency care there would seem to be a number of possibilities: one is that a specific package (similar to that under existing travel insurance programmes) could be purchased for use in the country (or countries) to which travelled; another is the use of “preferred provider networks”. This appears to be an important growth area as companies increasingly recognize the need to adapt the enabling and support services to the changing and liberalizing international environments. Many are also anxious to find innovative ways to differentiate the insurance product. From the patient’s perspective it can allow then access to preferential prices.

Two large insurance companies, namely CLICO and Sagicor both liase with internal organizations to facilitate their clients who may be travelling and fall ill. CLICO has forged links with Olympus Management Care Facility service where CLICO pays for their clients to have emergency cards. In case of illness these clients can contact Olympus who then would contact the hospital or agency where they received their care and take care of the invoicing procedures after the care was sought. CLICO also work alongside a top international reinsurance company called Swiss Re (www.swissre.com). Swiss Re is one of the leading global reinsurers who offer a wide range of traditional reinsurance products and related services, which are complemented by insurance-based corporate finance solutions and supplementary services. Their core business segments are: risk transfer, risk finance and asset management. Their financial strength receives excellent ratings from leading agencies. Swiss Re is a recognized expert in the field of risk and capital management. Swiss Re can be found in several locations globally. With more than 70 offices in 30 countries, Swiss Re's employees have the world at their fingertips. This presence allows them to serve their clients and colleagues in virtually every country the world over. Sagicor on the other hand has forged links with the Canadian Medical Network (CMN). In cases of emergencies, clients of Sagicor who possess their medical card can contact the company and arrange for them to settle all their medical bills without any problems.

Human Resource availability

As has traditionally been the case with other Caribbean countries this continues to be a fairly significant constraint in St. Lucia. Victoria Hospital has 40 doctors on staff of

which some 42.5% were recruited from Guyana. These consist of resident doctors (17), consultants (20) and junior officers (4) medical intern (1) and registrars (4). There are also cases whereby doctors/specialists are brought in from Trinidad to perform some surgeries and also to teach courses where there is no current specialization. It is a not-for-profit acute care general hospital with a bed capacity of 178 beds. The hospital serves a catchment area of approximately 104,000 (2003/2004) people in a geographic area encompassing Gros Islet to Canaries and Denery. The institution has with its bed capacity of 178 beds provides inpatient and outpatient services in the following disciplines: Accident and Emergency, General Medicine, General Surgery, Imaging and

Table SL6: Medical personnel in public sector by speciality, nos. & rates per 100,000 population - 2002

| CATEGORY | | |
|------------------------------|-----|------|
| | No. | Rate |
| General practitioners | 60 | 6.9 |
| General surgeons | 4 | 2.5 |
| Anaesthetists | 5 | 3.1 |
| Paediatricians | 3 | 1.9 |
| Obstetricians/Gynaecologists | 5 | 3.1 |
| Psychiatrists | 5 | 3.1 |
| Physicians | 8 | 5.0 |
| Accident & emergency | 4 | 2.5 |
| Epidemiologists | 1 | .06 |
| Cardiologists | 1 | .06 |
| Dermatologists | 1 | .06 |
| Internists | 2 | 1.3 |
| Nurses | 302 | 190 |
| Nursing Assistants | 52 | 33 |
| Ophthalmologists | 1 | .06 |
| Pathologists | 1 | .06 |
| Radiologists | 2 | 1.3 |
| Orthopaedic surgeons | 3 | 1.9 |

Source: Ministry of Health, Human Services, Family Affairs and Gender Relations. Report of the Chief Medical Officer, St. Lucia

Radiographic Services, Obstetrics and Gynaecology, Paediatrics, Cardiology, Nephrology (including Haemodialysis), Orthopaedics, Ophthalmology, Otolaryngology (ENT), Intensive Care (ICU), Anaesthesia and Pathology (laboratory Services). In Table SL6 the human resource situation is presented. There it will be seen that with the exception of nurses the ratios are relatively modest.

There are now systems in place for the standardized training of nurses and physicians – thereby removing one barrier to the deployment of skills in different countries within the region. There is a fairly strong political commitment to the achievement of freedom of movement for skilled labour – especially within the developing frameworks of the Caribbean Single Market Economy [CSME]. Although a number of “kinks” which hinder perfectly smooth movement still need to be ironed out there has been significant improvement in this area. However, there continue to be fairly serious bottlenecks in terms of the quantum and range of skill-types available. Medical specialists as well as some of the skills (for example, for pain management treatments, acupuncture, ayurvedic treatments) that would be required in a facility that offers sophisticated body health services are in very short supply, and must often be imported. Even more important is the limited local absorptive capacity for the numbers trained. There is a serious brain-drain of nurses and physicians to the developed countries

The Victoria Hospital deals with this problem by importing from the Guyanese market. Out of the 40 doctors, some 42.5% were recruited from Guyana. These consist of resident doctors, consultants and junior officers. There are also cases whereby doctors/specialists are brought in from Trinidad to perform some surgeries and also to teach courses where there is no current expertise. Health professionals such as doctors and nurses working in areas such as radiography are recruited from Guyana, India and Africa. The Tapion Hospital for instance, engages in telemedicine with Martinique - a project that was initiated by the French. There are local visiting specialists from Martinique and Barbados who specialized in haematology, there is also a plastic surgeon from Anguilla and the St Lucia Pain Management Institute imports a neuro-surgeon every quarter to perform services in St Lucia.

Currently, there are complaints that access to the medical tertiary level education available in Caribbean institutions has become too costly. Governments are increasingly looking for opportunities in countries such as Cuba where students can gain scholarships, and the local government does not have to bear the economic costs. At the same time, local access to the “off-shore” medical schools are either non-existent or very limited. At present, there are five medical schools (three operational, US, Arab and African), within St Lucia, where non-CARICOM individuals come for training. An inter-ministerial committee currently regulates the growth of these medical schools. These schools have to go through the National Development Corporation and the Ministry of Trade in order to set up for business. However, the main benefits to the government and national economy would appear to be in the form of licensing fees, the payment of rentals, and the purchase of local ancillary support services.

Nevertheless the human resource availability issue could be helped if students and staff were to provide services and technical assistance to health facilities in the area. The government of St Lucia does in fact see the presence of the medical schools as an opportunity. One possibility could involve the training of nurses and personnel at the medical schools; these trained persons could be exported and also used within the local market. The use of consultancy services could also be considered. . This not only has

potential for medical training, but also for the transference of best practices. There are also possibilities whereby laboratory services could be provided through telemedicine linkages between local, offshore and extra-regional facilities. Where this kind of arrangement develops then there could be longer-term possibilities for jointly offering services on the international markets at competitive rates.

Finally here, it needs to be noted that any efforts to address the human resource inadequacies would also need to focus particular attention on building up the skills in that area of customer service. It has to be recognised that not only must prices be internationally competitive, but demand for these types of products will be extremely sensitive to the quality of the customer service.

CONCLUSIONS

This review of the situation in Trinidad and Tobago and in St. Lucia shows that while there is general and even increasing support in political, medical, and business circles for expanded trade in health services, in reality, there is little active promotion, and relevant support systems and structures remain relatively undeveloped. Most of the recommendations made in the earlier study by Gonzalez et al [2001] therefore remain very relevant and pertinent. Certainly there are differences in the infrastructure and resource situations in each country, such that the type of health tourism that could be developed will no doubt (and perhaps ought to) be different. Thus for example, in Trinidad & Tobago emphasis may be on the increased, more innovative and even expanded use of existing health and medical treatment services, whereas in St. Lucia - where traditional tourism has come to be the mainstay of the economy - it is likely to be more advantageous to focus attention on wellness and rehabilitative programmes. Both countries nevertheless face problems related to the health and economic inequalities. Any efforts to develop this area of activity must therefore necessarily seek to find ways whereby its expansion reduces rather than exacerbates those inequalities. It also seems clear that given the current distribution of resources activities are likely to be largely private-sector driven. Even so, success will be limited without a supportive and facilitative relationship with the public sector. Recent advances in telecommunications, and international health insurance, the growing fascination with fitness and wellness – internationally and locally - as well as rising health costs in the developed countries have helped to both create windows of opportunity for countries in the Caribbean region, and reduce some of the barriers to this kind of trade that may have hitherto seem insurmountable. Caribbean countries need to move quickly and resolutely – either in intra and extra regional partnerships – if they are to efficiently and productively capture the opening spaces. The following would then seem necessary:

- ∓ Establish, reactivate or strengthen mechanisms that can facilitate public-private sector partnerships. In this regard, health sector development and reform programmes ought to focus specific attention on strategies that can ensure mutually beneficial relationships between expanding health tourism and public health improvements;
- ∓ Build on, and innovatively expand existing intra-regional cooperation and trade in health services in ways that will achieve satisfactory balance between the most efficient use of the region's resources, an increase in the earnings from health tourism, and health equity at the national levels;
- ∓ Encourage the growth of Foreign Direct Investment in ways that will spur the influx of health tourists, increased familiarity with the health providers in the region, and facilitate the growth of local entrepreneurs;
- ∓ Strengthen, modernise, and streamline the regulatory framework, and systems for the monitoring of private sector activity;
- ∓ Strengthen and clarify the incentive programmes – especially in ways that will facilitate transparency and institutional predictability;

- € Continued review of trade negotiating requirements so as to ensure that CARICOM proactively adjusts to the changing global environment as it relates to the health and professional services.

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Annex 1

Table 1: Share of Other Services in Current GDP for Selected Caribbean Countries

| Country | 1997 | | | | 1996 | | | |
|--------------------------------|------------|----------------|-----------|----------------|------------|----------------|-----------|------------------------|
| | Total GDP | Other Services | Share GDP | Growth 1996-97 | Total GDP | Other Services | Share GDP | Comment |
| Anguilla (EC\$ million) | 192.05 | 3.48 | 1.81% | 14.85% | 175.75 | 3.03 | 1.72% | |
| Antigua/Barbuda (EC\$ mill) | 1,414.00 | 98.10 | 6.94% | 7.57% | 1,227.40 | 91.20 | 7.43% | |
| Barbados (Bds \$ million) | 4,370.60 | 611.00 | 13.98% | 2.02% | 3,993.40 | 598.90 | 15.00% | General Services |
| Dominica (EC\$ million) | 557.10 | 8.50 | 1.53% | 4.94% | 543.40 | 8.10 | 1.49% | |
| Grenada (EC\$ million) | 701.20 | 19.90 | 2.84% | 5.85% | 662.50 | 18.80 | 2.84% | |
| Guyana (G\$ million) | 88,926.00 | 1,315.00 | 1.48% | 10.23% | 82,258.00 | 1,193.00 | 1.45% | |
| Jamaica (J\$ million) | 220,556.20 | 9,176.80 | 4.16% | 15.07% | 203,109.00 | 7,975.30 | 3.93% | Miscellaneous Services |
| Montserrat (EC\$ million) | 94.70 | 6.20 | 6.55% | -54.74% | 113.10 | 13.70 | 12.11% | |
| St. Kitts/Nevis (EC\$ million) | 611.70 | 27.20 | 4.45% | 12.86% | 555.80 | 24.10 | 4.34% | |
| St. Lucia (EC\$ million) | 1,317.90 | 65.40 | 4.96% | 3.65% | 1,286.40 | 63.10 | 4.91% | |
| St. Vincent/Gren. (EC\$) | 648.60 | 11.10 | 1.71% | 2.78% | 629.50 | 10.80 | 1.72% | |
| Trinidad/Tobago (TT\$ mill) | 36,969.70 | 1,817.60 | 4.92% | 1.97% | 34,648.00 | 1,782.50 | 5.14% | Personal Services |
| Average | | | 4.61% | 2.25% | | | 5.17% | |

Source: United Nations Economic Commission for Latin America and the Caribbean, Subregional Headquarters for the Caribbean, Caribbean Development and Cooperation Committee, "Selected Statistical Indicators of Caribbean Countries," LC/CAR/G.544, Vol. XI, 1998.

Table 2: General Services Origin of GDP in Barbados: 1978-1995 (Current Prices)

| Year | Total GDP | General Services | % Share of General Services | Growth Rate General Services | Growth Rate of GDP |
|----------------|------------------|-------------------------|------------------------------------|-------------------------------------|---------------------------|
| 1978 | 984.4 | 37.8 | 3.84% | | |
| 1979 | 1,196.1 | 46.1 | 3.85% | 21.96% | 21.51% |
| 1980 | 1,489.8 | 57.7 | 3.87% | 25.16% | 24.55% |
| 1981 | 1,706.2 | 69.4 | 4.07% | 20.28% | 14.53% |
| 1982 | 1,784.2 | 76.7 | 4.30% | 10.52% | 4.57% |
| 1983 | 1,989.9 | 80.9 | 4.07% | 5.48% | 11.53% |
| 1984 | 2,074.6 | 85.7 | 4.13% | 5.93% | 4.26% |
| 1985 | 2,180.6 | 89.6 | 4.11% | 4.55% | 5.11% |
| 1986 | 2,297.3 | 94.1 | 4.10% | 5.02% | 5.35% |
| 1987 | 2,498.9 | 97.3 | 3.89% | 3.40% | 8.78% |
| 1988 | 2,667.6 | 99.2 | 3.72% | 1.95% | 6.75% |
| 1989 | 2,090.5 | 106.1 | 5.08% | 6.96% | -21.63% |
| 1990 | 2,965.3 | 109.3 | 3.69% | 3.02% | 41.85% |
| 1991 | 2,892.6 | 109.7 | 3.79% | 0.37% | -2.45% |
| 1992 | 2,703.0 | 107.7 | 3.98% | -1.82% | -6.55% |
| 1993 | 2,791.2 | 110.6 | 3.96% | 2.69% | 3.26% |
| 1994 | 2,920.7 | 122.0 | 4.18% | 10.31% | 4.64% |
| 1995R | 3,136.6 | 131.8 | 4.20% | 8.03% | 7.39% |
| 1996E | 3,377.0 | 146.1 | 4.33% | 10.85% | 7.66% |
| <i>Average</i> | | | 4.06% | 8.04% | 7.84% |

Source: Ministry of Finance and Economic Affairs, "Barbados Economic Report, 1996," September 1997.

| Country | GDP/Capita (US\$ 1995) | National Health Expenditure as a % of GDP | Per Capita National Health Expenditure | Share of Private Financing |
|---|-------------------------------|--|---|-----------------------------------|
| Anguilla | \$6,584 | 5.1% | \$336 | 47% |
| Antigua & Barbuda | \$8,110 | 6.1% | \$496 | 39% |
| Bahamas | \$11,940 | 4.3% | \$518 | 42% |
| Barbados | \$6,560 | 6.4% | \$421 | 38% |
| Belize | \$2,696 | 3.9% | \$106 | 54% |
| Dominica | \$2,990 | 6.6% | \$198 | 40% |
| Grenada | \$2,980 | 5.0% | \$150 | 47% |
| Guyana | \$590 | 7.5% | \$44 | 31% |
| Jamaica | \$1,510 | 5.0% | \$76 | 51% |
| Montserrat | \$5,893 | 6.5% | \$383 | 37% |
| St. Kitts & Nevis | \$5,170 | 5.6% | \$289 | 43% |
| St. Lucia | \$3,370 | 5.0% | \$167 | 48% |
| St. Vincent & the Grenadines | \$2,280 | 5.5% | \$125 | 36% |
| Suriname | \$1,118 | 8.0% | \$95 | 25% |
| Trinidad & Tobago | \$3,370 | 4.7% | \$176 | 55% |
| Average | \$4,344 | 5.7% | \$239 | 42% |
| Range | \$590 - \$11,940 | 3.9% - 8.0% | \$44 - \$518 | 25% - 55% |
| Source: Pinto, M., "Broadening Financing Options in the Eastern Caribbean: Lessons Learned and Next Steps," | | | | |
| Workshop on Health Sector Reform, St. Lucia, 4-6 May, 1999. | | | | |