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The globalization of the health-care industry: opportunities for the Caribbean

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The globalization of the health-care industry is proceeding. It is being driven by the high cost of health care in the developed countries, compounded by the steep rise in demand for health care as a result of the ageing of populations in these countries and the increasing availability of health-care services in developing countries at less expensive rates than in developed countries. Increasingly, patients are sourcing health care globally and opting for the most affordable treatment. In a growing number of fields of treatment, the most cost-effective option is travelling to a developing country. The provision of health care has significant potential for those developing countries that can provide world-class services and facilities at internationally competitive prices. The proximity of the Caribbean to the United States gives it an additional advantage in meeting the rapidly growing demand for health care originating in that country.

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investment grew at rates that exceeded the growth rates of international trade and world output (United Nations, 1994).

Competition in global markets has intensified among firms and countries as the world economy has become more integrated. The implication of global competition is that even goods and services that are produced and exchanged within the national markets have to meet standards of quality and compete with costs of production available globally. The fusion of computer technology with telecommunications makes it possible for firms to relocate an ever-widening range of operations and functions to wherever cost-competitive labour, assets and infrastructure are available. These technological developments have transformed organization structures, the nature of work, and the character of products, production techniques and international marketing.

As globalization proceeds **economic units are becoming larger**, as is evident from the enlargement of multinational corporations, and the integration of national economies to form regional economic or trade blocks (Bernal, 1997). These blocs are a prominent feature of the world economy, both in terms of the share of the world trade they encompass and the number of countries that participate in them. It is estimated that they are responsible for a half to two thirds of world trade (WTO, 1995; Carnegie Endowment for International Peace, 1997).

Multinational corporations (MNCs) now account for about a third of world output and a significant share of world trade. They also account for half of world trade in goods (Vernon, 1998), and 80% of the world's land cultivated for export crops (Stopford and Strange, 1991). Their dominance is also evident in the value of foreign assets they control, the volume of foreign sales and size of foreign employment (United Nations, 1998).

The trend towards enlargement of corporate entities and the dominance of the multinational corporation is likely to continue. Estimates of the share of cross-border mergers and acquisitions in world foreign direct investment vary between 76% (Barba Navaretti and Venables, 2004) and 83% (United Nations, 2000); in the European Union, mergers and acquisitions account for over 75% of foreign investment flows (letto-Gilles, Mexchi and Simonetti, 2000).

Services are the fastest growing component of the world economy; indeed during the 1990s services exports of developing countries grew more rapidly than exports of manufactured goods (World Bank, 2001). The average annual growth in trade in services between 1990 and 2000 was 7%, compared with 6% for merchandise trade (WTO, 2003).[1] The overall share of services in total trade was 22.2% in 1993 (up from 17% in 1980), and service industries accounted for 50% to 60% of total foreign direct investment flows (World Bank, 1995; United Nations, 2001). Furthermore, services account for 65% of GDP in high-income countries and between 38% of GDP in low-income countries (World Bank, 2000).

The increasing globalization of economic transactions and activities has been facilitated and in some instances promoted by the rapid development of **new information, communications and manufacturing technologies**. The new developments in information-processing, and telecommunications facilitate globalization by reducing the costs resulting from distance, the importance of location and the advantages of large size. The use of electronic technology has altered fundamentally the conduct of financial services, telecommunications, entertainment and various other services and is projected to grow exponentially (WTO, 1998).

As regards **governance**, the process of globalization involves the coalescing of national markets into global markets. For example, the global financial architecture has been transformed from one constituted by nation-States with some transnational links to a predominantly global system in which some residual local differences in markets, institutions, and regulations persist as vestiges of a bygone era. The capability of governments to manage their economies is increasingly constrained by multilateral organizations, multinational corporations and transnational financial institutions, which increasingly wield economic and political influence that is global in scope (Strange, 1996; Korten, 1995).

The policy autonomy of the nation-State is also weakened by the prominence of multinational corporations, which, by their global span, internationally linked production and intra-firm trade, transcend the reach of the nation-State. A quarter of world trade consists of intra-firm transactions, that is, taking place within multinational corporations (UNCTAD, 1994) and consequently this substantial portion of world trade and capital movements is beyond the control of governments and insulated from global and national market forces.

[1] For a more in-depth study of the trends, see Maurer and Chauvet (2002).

in character. The intensification of competition which generally accompanies the increasing dominance of the global market is not a major factor influencing national health-care systems. At the high-income end of the market and in certain specializations a limited number of institutions in developed countries have achieved global reputations as leaders and the demand for their services emanates from all over the world.

3. Nascent enlargement

While the health insurance entities, hospitals and health-care providers in the private sector of developed countries have experienced consolidation and mergers, there are few genuine multinational corporations in this sector. This is largely because of the significant differences in national regulatory regimes, which have inhibited the global expansion of corporations that are sufficiently large to marshal the necessary human and financial resources to undertake such ventures abroad. The global spread of health-care corporations is likely to take place first in jurisdictions where there has been a standardization of regulations among a group of companies and points of entry will be those countries that make it relatively easy for foreign health-care providers to establish and operate. However, several multinational corporations involved in manufacturing pharmaceutical and medical supplies have well-established distribution networks in developing countries.

Many developing countries, particularly in Latin America and Asia have significant private medical sectors. A substantial number of hospitals and other health facilities are privately owned and even in low-income countries more than half of basic health services are provided by private practitioners. Several United States multinational corporations including Aetna, American Insurance Group, CIGNA and Prudential are operating in Latin America. They entered the market in the 1990s by acquiring through purchase or joint venture local companies that provide pre-paid health plans and indemnity insurance (UNDP, 2003). Consortia of corporations and strategic corporate alliances are beginning to emerge; for example, the Apollo hospital group is building 15 hospitals in Malaysia, Nepal and Sri Lanka. The Parkway Group of Singapore, which owns hospitals in the United Kingdom and Asia, has partnered with firms in Indonesia, Malaysia, Sri Lanka and the United Kingdom to form Gleneagles International to operate an international chain of hospitals (Chanda, 2002).

4. Growth of health-care services

Global expenditure on health care in 2005 is estimated to have amounted to US$ 4 trillion (UNCTAD, 1997), with OECD countries accounting for most of this expenditure (WHO, 2002). Spending on health care ranges from 14% of GDP in the United States to 1%-5% of GDP in developing countries, with the OECD countries spending 8% of GDP (Zarrilli and Kinnon, 1998). Per capita expenditure on health exhibits similar disparities ranging from $16 in low-income countries to $2,300 in high-income countries.

Despite rapid globalization, particularly in services, there is limited international trade in health-care services and transborder activity in health care. Most of the international exchange of health-care services consists of purchase of services in developed countries by persons travelling to those countries for treatment. The growth of international trade in health services is accelerating. Cross-border delivery is now worth $140 billion (World Bank, 2005) and is projected to grow at 6% per annum.

Some institutions in developed countries have begun to market their services and facilities internationally thereby boosting the global market. Johns Hopkins and the Mayo Clinics have achieved remarkable growth in foreign patients since they started marketing internationally in the 1990s (Freudenheim, 1996). Referral hospitals in the United States (e.g. Sloane-Kettering) are institutions of worldwide renown and have an international clientele. A growing number of less prestigious United States hospitals, in an effort to utilize their capacity to the full, have contracts with foreign firms, public sector institutions and trade unions throughout Latin America and the Caribbean (Warner, 1998). An interesting new trend is the movement of consumers in the developed countries to developing countries because they can access treatment, which is less expensive than in their home countries.[2] Another reason for seeking treatment abroad is to avoid extended waiting periods in national health systems and because in some cases they cannot afford private health care (Lunn, 2006). Increasingly, health care and tourism are being combined and have been labelled "sun, sea and surgery" (Prosser, 2006; Sankaranarayanan, 2005).

[2] For example, British citizens have traveled to Spain, Turkey, Eastern Europe and India to avail themselves of medical and dental services at prices which are as much as 50% lower than in Britain.

the driving forces impelling the globalization of the industry and secondly, barriers to globalization.

1. Driving forces

There are a number of factors which are encouraging the globalization of health care. These include:

(a) *Cost differentials*

The cost of providing health care is substantially lower in developing countries than in the developed countries. For example, the cost of coronary by-pass surgery in India is 5% of the cost in developed countries and a liver transplant in India costs one-tenth of that in the United States (Gupta, Golder and Mitra, 1998). A magnetic resonance imaging (MRI) scan costs US$ 60 in India compared with US$ 700 in New York (Lancaster, 2004). Cardiac by-pass surgery in Trinidad and Tobago is about 50% less expensive than in Boston, United States (World Bank, 1996). Hip resurfacing costs US$ 5,000 in India compared with US$21,000 in the United States (Lancaster, 2004). A facelift in the British Virgin Islands is 30% less expensive than in the United States; a 28-day stay for addiction treatment including medical "detoxification" in Antigua is half the cost of a similar treatment in the United States, and many spas in Jamaica and St. Lucia provide comparable services at a lower cost than in Florida, United States (World Bank, 1996).

The cost differentials between developed and developing countries are attributable to various factors as indicated below:

(i) Salary and wage differences are substantial. For example, a nurse in the Philippines earns the equivalent of about 5% of what he or she would be paid in the United States (Stalker, 2001). A registered nurse in the Washington, DC, area can earn three times as much as his or her counterpart earns in Barbados (CARICOM Secretariat, 2006).

(ii) The cost of malpractice insurance is lower in developing countries than in the United States. It is estimated at $100,000 in the United States, compared with $4.000 in India (Lancaster, 2004).

(iii) The cost of inputs and outsourced services tends to be lower in developing countries because of lower labour costs across all sectors. For example, drugs supplied from outside the developed countries, notably from India, Brazil or from less expensive developed country sources, such as Canada, are much less costly than the equivalent medicine made in the United States. Part of the high cost of drugs in the United States is the well-documented exorbitant profits made by pharmaceutical companies (Ledogar, 1975; Greider, 2003).

Given the difficulties involved in the temporary movement of health-care professionals between countries and the even more contentious issues that restrict migration, salary and wage differentials between the developed countries and developing countries will remain high for the foreseeable future. The developed countries when faced by severe shortages in certain categories of skilled workers have liberalized conditions of entry to alleviate the shortage in specific sectors. When faced with (i) investment, jobs and capacity in the rapidly growing informatics sector going overseas in search of qualified labour, (ii) increasing international outsourcing of business or (iii) paying higher wages to attract workers away from other occupations, these countries, developed countries have liberalized access for foreign workers. For example, the United States, under pressure from Congress and the computer industry (Pear, 1998), permitted increased entry of qualified foreigners. In 2000, Congress raised the limit on H-1Bs (temporary visas for skilled foreigners) and exempted certain categories of labour from limits (Alvarez, 2000). In 1998, following representations from the private sector, the Government of Canada implemented speedier processing of approval of entry of temporary workers.

In light of the ageing of the population in developed countries, such as the United States, Canada and the United Kingdom, and the implications for stagnation or shrinkage of the workforce (Robson, 2001), further liberalization may be necessary. This is a probable scenario for the health-care sector in the developed countries where the demand for health services, particularly for the aged, is outstripping supply capacity. Already in the British National Health Service, 31% of doctors and 13% of nurses are foreign born and in London, the figure for nurses is 47%. Of the 16,000 new staff recruited in the last decade, half were trained overseas (Stalker, 2001). In the United States, it is estimated that the shortage of nurses in 2004 was 139,000 and the figure is predicted to increase to 275,000 in 2010[4] and 800,000 in 2020.[5]

[4] According to data from the American Nurses Association.

[5] According to data from the United States Department of Health and Human Services.

75% less expensive (Hilts, 1992). There is a growing trend towards persons in developed countries retiring abroad particularly to developing countries with a warm climate because their income purchases more abroad, than for example, in the United States. The market for retirement facilities will increase sharply in the next twenty years (*Business Week*, 1994). The small, developing countries in close proximity to the developed countries and which enjoy warm weather throughout the year and relatively lower wage levels constitute an environment suitable for the development of retirement communities.

(d) *Availability and cost of air travel*

The availability of affordable air travel has increased significantly with the expansion of tourism throughout the world. People are also more willing to travel for medical attention in most cases to developed countries but increasingly to countries with a reputation for quality health-care systems, such as Cuba. By the mid 1990s Cuba was receiving 25,000 foreign patients and earning $25 million from sales of health services (World Bank, 2002).

The cost of air travel will be an important factor in the overall expense of having treatment overseas in preference to having it in one's own country. The cost of air travel has been reduced relative to the growth in levels of income and the availability of air transport has increased. Close location to major developed country markets is only an advantage if there is adequate air transportation. However, if the savings are sufficient the cost of air travel will become irrelevant. For example, a patient in North Carolina in the United States, faced with a bill of US$200,000 for heart surgery, flew 7,500 miles to New Delhi, India, where the operation was successfully performed for a total cost of US$10,000, including airfare (Lancaster, 2004).

(e) *Global pandemics*

Infectious diseases account for one quarter to one third of all deaths globally. In 1999, new HIV infections rose from 40,000 annually to 46,000. The number of passengers travelling in the world has increased several-fold. The number of new diseases, the increasing resistance to known treatments by several existing diseases, and the rapid geographic spread of both are on the rise. Explanatory factors include human manipulation of plant and animal food and genetics, increasing travel of humans and some animals.

In the last 25 years, 20 diseases, which were in decline, have re-emerged and spread geographically and 29 previously unknown diseases have been identified, including HIV/AIDS, Ebola and hepatitis C. With more international trade and more mobility of people via tourism and migration (legal and illegal), the problem requires more international cooperation. It is estimated that in 2000 some 36 million people were living with HIV, the virus that causes AIDS, of whom 90% were in developing countries and 75% in sub-Saharan Africa. Less than 25,000 people in developing countries receive anti-retroviral treatment, which is routinely available in developed countries (WTO, 2001a).

Ultimately, the best defence against the spread of diseases such as tuberculosis and polio is preventative health care, in particular, immunization programs. Such programmes, when properly undertaken and where there is adequate coverage of the population, not only prevent untold human suffering and death but also are far more cost-effective than handling an epidemic or outbreak (Ashley and Bernal, 1985). Multilateral efforts based on cooperation through international organizations such as the World Health Organization (WHO) need to be increased in order to tackle global pandemics. The Global Fund to fight AIDS, Tuberculosis and Malaria is aiming to raise $7 billion. While this is a huge sum, it is nowhere near the $57 billion per annum in additional expenditure required to deliver essential medical services to the world population according to the Commission on Macroeconomics and Health (The Economist, 2001). International cooperation should include agreements on disease identification, containment, and treatment, and standard protocols and cost-sharing structures to ensure that poor and rich countries alike can control outbreaks of the most deadly diseases. Cooperative efforts must improve primary health-care systems and infrastructure in developing countries so that diseases originating in the tropics can be identified and eradicated before they spread (Barks-Ruggles, 2001).

(f) *Multilateral trade rules*

International rules governing trade such as those set out in the World Trade Organization (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), impinge directly on health care because they regulate the availability of pharmaceuticals. The TRIPS Agreement authorizes patents governing the production and the conditions of sale of drugs. This recently became an acrimonious issue between developing countries and major pharmaceutical manufacturers, all concentrated in developed countries. World production of drugs is concentrated in six countries —France, Germany, Italy,

personnel. Most of the movement of physicians and nurses is from developing countries to developed countries. The international movement of nurses (70% of health-care staffing (CARICOM Secretariat)) also raises issues of gender and international trade in health-care services (Williams, 2003).

The expansion of the coverage of health services in the GATS is an issue which will certainly have to be addressed in the future (Smith, Blouin and Drager, 2006), but at present there is no indication of when this will happen. Currently 54 WTO members have made commitments in medical and dental services, 44 members in hospital services and 29 members in services provided by nurses, midwives and others (Adlung and Carzaniga, 2002). Governments can liberalize trade in health services by unilateral action without making binding commitments in their national schedules under the GATS.

(c) *Lack of portability of health insurance*

A major factor inhibiting the globalization of the health-care industry is the lack of any form of health insurance, which is accepted worldwide; indeed, health insurance both of the public and private varieties are tenable only in the country in which the holder is domiciled. The fact that United States Medicaid and Medicare programmes are not valid for use overseas prevents United States citizens from seeking treatment abroad. Ironically treatment overseas may be less expensive than that available in the United States or drugs manufactured outside the United States may be less expensive or procedures not permitted in the United States may be available. Less costly treatment or drugs available would represent an enormous saving to a system which is under tremendous stress because of the exponentially escalating costs of delivering health care in the United States.

As the pressure grows on the health-care systems of developed countries in terms of both the volume of cases and the cost of services both public and private insurers will reluctantly concede the right of patients to be treated overseas. The overloaded British health-care system has begun referring patients for treatment in France and Spain. For the time being, patients are restricted to hospitals within three hours flying time from Britain (Lancaster, 2004), but even this is likely to be relaxed if patients are willing to bear the additional cost.

For the rich and top corporate executives, costs and health insurance do not constrain their decisions on where to obtain medical attention, their credit card rather than their health insurance cards being the means of payment. However, it cannot be long before an internationally portable form of health insurance is developed for highly paid, internationally mobile corporate executives. What will start at an exorbitant cost will, like all other global services, be reconfigured for the wider, less affluent global mass market. This will be followed by health insurers allowing their customers to source medical attention internationally starting with a restricted approved list of health providers and then extending to nationally accredited medical institutions in an ever-widening range of countries.

(d) *Need for standardization of accreditation*

Systems of accreditation vary widely and even where there are some similarities, for example, in the Commonwealth, systems are essentially national. Temporary or long-term accreditation of medical personnel involves convoluted, complicated and bureaucratic procedures. Much remains to be done in establishing educational equivalence, formalizing mutual recognition of qualifications, standardizing licensing requirements.

V

Pattern of globalization of the health-care industry

The globalization of the health-care industry and the global availability of health services will be influenced by several factors, prominent among which will be proximity between demand and supply, the mindset of those in need of medical care, national measures to promote foreign direct investment in medical facilities and the availability and relative cost of medical professionals.

but other factors include logistics, the reputation of the institution and the tenability of health insurance.

4. Policy and regulatory regime

Governments, in wishing to encourage the emergence of strong, internationally competitive health-care sectors, need, among other measures, to remove barriers to entry of professionals, meet developed-country standards, construct modern infrastructure and maintain good air-transport facilities.

Countries seeking to produce health-care services for the global marketplace must create a policy framework and a regulatory environment that facilitates and encourages the necessary investment, technology and staffing. In the case of developing countries, most of the capital and technology required for health-care services that are internationally competitive in price and quality will have to come from abroad. The critical components are a stable policy and regulatory framework that is consistent with current global standards, practices and intellectual property rights and strategic planning to attract and/or create brand-name health-care organization, provide modern infrastructure and a trained labour force. The improvement in physical and telecommunications infrastructure must not only focus on modernization but must take cognizance of the need to close the gap with developed countries. For example, developing countries cannot compete effectively if the number of telephone lines per 100 inhabitants is between 5 and 10, compared with 48 in developed countries (WTO, 1998).

The creation of synergies based on inter-sectoral linkages should be planned: for example, synergies between tourism and health care in countries where an existing tourism industry can be enhanced by the establishment of world-class health-care facilities. Tourism could be enhanced and diversified to include new products such as health tourism,[11] thereby spawning a new industry and reinvigorating an existing sector. This is a distinct opportunity for regions such as the Caribbean and Central America, which have large tourism industries and are in close proximity to a major developed country.

VI

Opportunities for developing countries in the Caribbean

As the health-care industry becomes more globalized, there will be opportunities for developing countries to export health-care services to developed-country markets. Developing countries in close proximity to developed countries and which have an adequate supply of medical personnel at salaries lower than in developed countries have the opportunity to provide health care to foreign patients at a cost below that in the developed countries. These are necessary but not sufficient conditions for creating a world-class offshore health-care industry. Opportunities can be transformed into reality if the government puts in place the type of policy and regulatory regime that stimulates investment by companies that are global brand names in health care. Such possibilities can be illustrated by reference to an actual situation, namely, that of Jamaica (Taylor, 1993).

1. Proximity

Jamaica is in close physical proximity to a major developed country, namely, the United States, which has an ageing population and a high-cost health-care system.

The city of Montego Bay, Jamaica, has an international airport which is one hour's flying time from Miami, 3 hours from Baltimore and 31/2 hours

[11] See Alleyne (1991, pp.291-300). Health tourism has been a largely overlooked issue in the extensive literature on tourism. Some publications do not make the slightest reference to the topic (see Yorghos Apostolopoulos and Gayle (2002) and Jayawardena (2005)). Ironically, the call for more attention to be given to health tourism comes from the health sector rather than the tourism sector. See CARICOM Secretariat (2006, p.23).

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