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TIJARA PROVINCIAL ECONOMIC GROWTH PROGRAM

HEALTH SERVICES IN IRAQ AND GATS NEGOTIATIONS

RECOMMENDATIONS AND IMPACT

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August 2009

This report was produced for review by the U.S. Agency for International Development (USAID). It was prepared by The Louis Berger Group, Inc.

Contract No. 267-C-00-08-0050-00

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ACRONYMS

CPA	Coalition Provisional Authority
DFID	UK Department for International Development
FDI	Foreign Direct Investment
FP	Family Planning
GATS	General Agreement on Trade in Services
GDP	Gross Domestic Product
GOI	Government of Iraq
IOM	International Organization for Migration
IQR	Iraqi Dinar
JV	Joint Venture
MCH	Maternal and Child Health
MFN	Most Favored Nation
MOH	Ministry of Health
NGO	Non Governmental Organization
PHC	Primary Health Care
OECD	Organization for Economic Co-operation and Development
SPS	Sanitary and Phytosanitary Measures
TBT	Technical Barriers to Trade
TRIPS	Trade Related Intellectual Property Rights
UAE	United Arab Emirates
UNCTAD	United Conference on Trade and Development
UNDP	United Nations for Development Programs
UNEP	United Nations Environment Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIDO	United Nations Industrial Development Organization
UNIFEM	United Nations Development Fund fro Women
UNRWA	United Nations Relief and Works Agency
US	United States
USAID	United States Agency for International Development
USD	US Dollar
WFP	World Food Programme
WHO	World Health Organization
WTO	World Trade Organization

1. INTRODUCTION AND METHODOLOGY

The purpose of this series of documents on various sub-sectors under services is to prepare the Government of Iraq (GOI) for the submission of the services chapter to the World Trade Organization (WTO). It also seeks to assist the GOI to better understand the context in which each sub-sector operates in the economy. WTO accession is hardly an end in itself. Instead, WTO Accession is the beginning of a process of serious economic reform. Accession to the "club" of WTO requires serious commitments to liberalization, as well as an understanding of the impact of these commitments on the economy at large and its broader benefits.

Each of the sub-sector reports is broken into five parts:

1. Introduction and methodology – the key analytical elements applicable to the sub-sector;
2. Sub-Sector Context within the General Agreement on Trade in Services (GATS) and Value Chain Development – the sub-sector in the context of GATS, international best practices, and value chain development of the sub-sector;
3. Iraq and the role of the specific sub-sector, including the regulatory environment, data, and the role of the private sector in WTO negotiations;
4. Recommendations for Iraq in the negotiations of the sub-sector;
5. A general discussion of the impact of the proposed liberalization commitments on Iraq in the sub-sector.

Section 2 describes the framework, or the "lens" through which the Iraqi Government Services Committee should consider in the analysis of their sector. The WTO framework, its modes, horizontal commitments and value chain underpin the essence of preparation, and are the main content of impact analysis.

Sections 3-5 provide a more detailed analysis of the sub-sector itself and its role and overall impact on the Iraqi economy.

There are five key methodological tools and concepts used to analyze the role of services in Iraq. These include:

a. WTO framework (definition of "modes");
b. International best practices;
c. Regulation;
d. Mode analysis;
e. Most Favored Nation (MFN) status, National Treatment and Market Access.

In each case we need to make sure that the GOI clearly understands the framework and context of the sub-sector analyzed and its relationship to the Four Modes contained in GATS.

Iraq applied for WTO accession in December 2004 and submitted a Memorandum on the Foreign Trade Regime in September 2005. The Working Party met for a second time in April 2008 to continue the examination of Iraq's foreign trade regime, however Services negotiations did not commence.

This study has been prepared as a background paper supporting Iraq's accession to the WTO. As part of the WTO accession process, Iraq must negotiate offers/commitments for Trade in Goods and for Trade in Services. The Iraqi Services sector is likely to be of particular interest to WTO members, due to its significant economic potential. An extensive consultation process underpins this study, which involved attending relevant meetings to make presentations and exchange information, meeting with experts in the government and civil society, and undertaking dialogue in an electronic discussion.

This study will be presented at various meetings of the GOI Services Committee. In addition to this paper, there are several lengthy presentation materials prepared by the Trade Division that will discuss various aspects of this paper in greater detail. Working Committee meetings will include members of civil society, as well as trade negotiators from Iraq. In the writing of this paper, consultation was undertaken in the form of face-to-face meetings with a range of stakeholders representing national and regional organizations.

2. SUB-SECTOR CONTEXT IN GATS

2.1 WTO DEFINITION AND FRAMEWORK

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

Any liberalization under GATS should aim to produce better quality, affordable, and effective health-related services, leading to greater equity in health outcomes. Liberalization should also ensure the necessary policy and regulatory space governments require to promote and protect the health of their populations, particularly those in greatest need.

2.1.1 Content of the negotiations on health services

Health services according to GATS included several sectors included either in the chapter “health related and social services” or in the one called “business services”.

Under Article XIV of GATS, WTO members are entitled to take any measure necessary to protect human, animal or plant life or health, regardless of their obligations under the Agreement. The same provision applies as under Article XX of the GATT: application of a measure must not discriminate arbitrarily or unjustifiably between countries where like conditions prevail, it must not constitute a disguised restriction on trade in services.

Like any other trade measure, action under Article XIV may be challenged by affected countries under the WTO dispute settlement mechanism if they feel that the relevant provisions have not been respected.

2.1.2 Services provided in the exercise of governmental authority

Services provided in the exercise of governmental authority, are exempt from the scope of the GATS, and thus from its rules and disciplines. This exemption applies to services that are provided neither on a commercial basis nor in competition. It is clear that in those sectors governments will be unable to undertake commitments. If private and governmental services coexist in the same jurisdiction, governments can still consider commitments on the former.

2.1.3 Scope and coverage of the GATS on health services

The health sector is affected by the General Agreement on Trade in Services (GATS), as it covers the movement of consumers and providers across borders to receive and supply health care, foreign direct investment in health, and the emerging areas of e-commerce and telehealth.

Cross-border supply of health services (mode 1): The possibility of providing certain health services across distance and, by implication, across national borders, is closely related to the advent of new communication technologies. While tele-health services were largely unknown 10 or 15 years ago, they may now be used to substitute or complement the local provision of a limited number of medical or hospital services.

Consumption of health services abroad (mode 2): Health service exports, via the treatment of foreign patients entering their territory (mode 2), are considered and used by some countries as an instrument of economic development. A growing number of lower-income countries seek to specialize in traditional medicine and/or rely on their price competitiveness vis-à-vis higher-income countries. At the same time, many suppliers in high-income countries seek to provide more sophisticated high-tech services to patients, domestic and foreign. However, in both situations, trade opportunities are affected by trade or health-related policies in the home countries of the patients. In other words, countries that want to attract foreign patients would seek commitments under mode 2 from other countries.

Commercial Presence (mode 3): A world-wide trend toward increased private sector involvement in health services and health insurance has in some countries been accompanied by increasing presence of foreign investment, including in the form of joint ventures. To the extent that countries want to encourage foreign investment in the health sector, GATS commitments in mode 3 (commercial presence) are an interesting option.

Movement of natural persons (mode 4): Commitments on mode 4 apply to measures governing the supply of services by foreign natural persons within the relevant Members' jurisdiction. An Annex to the GATS clarifies that the Agreement does not apply to measures governments may want to use to restrict access for foreigners that seek employment, citizenship or residence on a permanent basis. If foreign health workers are seen as a desirable way to alleviate health professional shortages and/or attract new expertise and skills, countries might undertake GATS commitments under this mode.

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2.1.4 WTO classification

Sectorial classification	Definition
1. Business services	
A. Professional services […]	
h. Medical and dental services – CPC9312	Preventive services, diagnostic, disease treatment without any hospital care
i. Veterinary services- CPC 932	Veterinary services for pets and other veterinary services – medical services, surgery etc.-

j. Services provided by midwives, nurses, physiotherapists and para-medical personnel – CPC 93191	Services including for example: medical supervision of pregnancies and childbirth, hospital care not taking place at the hospital, advice and prevention for patient at home
k. Other	-
8. Health related and social services	
A. Hospital services – CPC 9311	Services provided essentially to hospitalized patients under the supervision of doctors to cure, reactivate and/ or stabilize their health condition
B. Other human health services – CPC 9319	Ambulance services, health houses services other than hospitals such as anatomopathology or biochemistry, bacteriology, virology, immunology, etc. and services non classified elsewhere such as blood donor centers
C. Social services – CPC 933	Social services with or without accommodation: nurseries, centers for handicapped people, services of professional re-adaptation
D. Other	-

'Other health services' include laboratory, epidemiological and residential health services, as well as podiatry and chiropody services supplied in clinics and elsewhere.

2.1.5 The 4 modes of supply

Trade in services is defined by reference to four modes of supply.

- In mode 1- *cross border supply*- it is actually the service and not the service supplier that crosses the national border (*e.g.* telemedicine)
- Mode 2 – *consumption abroad*- involves the consumption of a service abroad (*e.g.*, medical tourism in Iraq).
- Mode 3 – *commercial presence*- entails the commercial presence of a supplier of one country in the jurisdiction of another country (*e.g.*, Foreign companies investing in a hospital in Iraq).
- Mode 4 – *presence of natural persons*- covers the supply of services by service suppliers through the (temporary) presence of natural persons (*e.g.*, foreign doctors or nurses deployed in Iraq).

2.2 WTO MEMBERS AND HEALTH SERVICES

Technological or practical constraints may render some modes of trade unfeasible, for example, cross-border supply (Mode 1) of nursing services. Nevertheless, rapid improvements in telecommunications infrastructure coupled with falling costs have allowed for the supply of medical on a cross-border basis.

Both the novelty of the concept and concerns about appropriate regulatory enforcement may have caused many Members not to undertake commitments under this mode. In the four relevant health services sectors, the share of non-bindings ("unbound") is higher for mode 1 than for any other mode. For example, half of the 50-odd commitments made on medical and dental services fall within this category.

Though data on individuals crossing borders to purchase health services is not collected systematically, consumption abroad (Mode 2) is thought to be growing. Several countries have identified 'health tourism' as an economic development opportunity, whether by providing complex tertiary services at lower cost, bundling health services and marketing them to foreigners, or providing services to returning expatriates.

More than half of all mode-2 commitments on medical and dental services, hospital services and other human health services are without limitations. These high shares may reflect, to some extent, Members' view of consumption abroad as a possible response to a shortage in domestic health service capacity. Also, governments may have felt that their ability to prevent nationals from leaving the country and consuming services abroad is limited in any event. Without complementary domestic policies, especially portability of insurance coverage for services received abroad, consumption abroad remains an option only for well-to-do patients.

"Commercial presence" (Mode 3) relates to the legal establishment of a foreign service supplier in the territory of the Member concerned. In most cases, foreign investment (FDI) is involved. In turn, such investment tends to be associated with technology transfer; in the health field, this might take the form of modern hospital or health insurance management practices.

Over 40 WTO Members have scheduled GATS commitments in mode 3 for the hospital services sub-sector, often subject to limitations which may be sector-specific (close to 30 cases) or horizontal (less than 10). It is reasonable to assume that these commitments are mostly in line with status quo conditions, rather than liberalizing market access or national treatment. Moreover, it may be worth mentioning that about 80 WTO Members have made market access commitments relating to foreign commercial presence by health insurance companies, through sectoral commitments in financial services covering the relevant subsectors. The vast majority of such commitments are partial commitments, mostly indicating limits on the number of operators or types of legal establishment that are admitted in the market. It does not appear that these commitments represent an explicit effort to encourage investment by foreign health insurers; rather, health insurance is covered as part of an overall approach to scheduling commitments on insurance.

Presence of natural persons (Mode 4), although accounting for only a limited share in total trade flows, is the most visible of the four modes of supply in health services. The movement of health professionals from less developed to more developed countries is the most prominent example of this mode of health service trade.

To date, most GATS mode 4 commitments have remained very limited in breadth and depth. There is evidence in many cases that actual policies provide better access conditions for foreign health professionals than those bound under the GATS. So far, close to 50 Members have made partial commitments for medical and dental services and less than 30 for midwife services, under mode 4. A partial commitment means that the country concerned has reserved the right to place specified limitations on those who seek access. In turn, this increases the predictability of restrictions the country may elect to operate. In current schedules, no WTO Member has made a full commitment on health services in mode 4.

Overall, it appears that the commitments undertaken for hospital services carry less stringent limitations, and are thus "more liberal", than those made for the other health services. This can be observed for developing as well as developed economies.

Of all sub-sectors, medical and dental services are the most heavily committed (54 Members), followed by hospital services (44 Members) and services provided by nurses, midwives, etc. (29 Members)[1].

[1] WHO, Rudolf Adlung and Antonia Carzaniga: “Health services under the GATS”, 2001

3. THE HEALTH SECTOR

3.1 DEFINITION

The WHO defines health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity". "Public health" refers to all organized measures (whether public or private) to prevent disease, promote health, and prolong life of the population as a whole.

Cross-border delivery of trade (mode 1)
Cross-border delivery includes shipment of laboratory samples, diagnosis, and clinical consultation via traditional mail channels, as well as electronic delivery of health services, such as diagnosis, second opinions, and consultations. Countries use a variety of telehealth services, including telepathology, teleradiology and telepsychiatry. Many cross-border telemedicine initiatives have also emerged.

Consumption of health services abroad (mode 2)
Consumption abroad refers to the movement of consumers to the country providing the service for diagnosis and treatment. Under this mode, affluent patients in developing countries seek specialized high-quality treatment overseas in hospitals in industrialized countries or in neighboring developing countries with superior health care standards. Patients from industrialized countries seek affordable, high-quality treatment or alternative medicines and treatments in developing countries.

Commercial presence (mode 3)
Commercial presence involves the establishment of hospitals, clinics, diagnostic and treatment centres, and nursing homes.

Movement of health personnel (mode 4)
Health services are also traded via the movement of health personnel, including physicians, specialists, nurses, paramedics, midwives, technicians, consultants, trainers, health management personnel, and other professionals. The movement of health care professionals includes both temporary and permanent flows, each having different legal, social and economic implications for both source and host countries.

3.2 HEALTH IN THE WORLD ECONOMY AND AT THE WTO

On the whole, people are healthier, wealthier and live longer today than 30 years ago. If children were still dying at 1978 rates, there would have been 16.2 million deaths globally in 2006. In fact, there were only 9.5 million such deaths. This difference of 6.7 million is equivalent to 18 329 children's lives being saved every day. The once revolutionary notion of essential drugs has become commonplace. There have been significant improvements in access to water, sanitation and antenatal care[2].

[2] WHO: The world health report 2008, Primary health care now more than ever.

3.2.1 Health data

The global health economy is growing faster than gross domestic product (GDP), having increased its share from 8% to 8.6% of the world's GDP between 2000 and 2005. In absolute terms, adjusted for inflation, this represents a 35% growth in the world's expenditure on health over a five-year period[3].

The health care sector is among the most rapidly growing sectors in the world economy. It is estimated to generate USD 3 trillion per year in countries in the Organization for Economic Co-operation and Development (OECD).

3.2.2 Health market trends

Most foreign investors find it risky to invest in developing nations, where only a few can afford private treatment and/or insurance. It is therefore more common to see FDI through joint ventures with local partners to ensure access to qualified personnel and a better understanding of local culture and characteristics[4].

International trade in health services is growing in many areas. Health professionals are moving to other countries, whether on a temporary or permanent basis, usually in search of higher wages and better working conditions. There have also been notable increases in foreign investment by hospital operators and health insurance companies in search of new markets. In addition, growing numbers of countries are seeking to attract health consumers from other countries[5].

Trade in health services is minimal, particularly when compared to other traded services[6]. However, this trade may grow rapidly as information and communication technology make it easier—for example, through ehealth—.

3.2.3 Role of health in economic development

Health is a key precondition to economic development. The burden of disease in some low-income regions is a major challenge to economic growth and must therefore be addressed directly in any comprehensive development strategy. This burden includes severe under-nutrition and devastating diseases associated with extreme poverty— such as HIV/AIDS, malaria, neglected tropical diseases and tuberculosis—as well as non-communicable diseases like depression, cardiovascular disease and diabetes[7].

Stronger health systems will have significant and wide-reaching impacts on the potential of societies to develop. With increased prevention of morbidity, faster and more effective resolution of prevalent illnesses, and overall nurturing of healthier communities, people can

[3] WHO: The world health report 2008, Primary health care now more than ever.
[4] Richard D Smith: Foreign Direct Investment and trade in health services: a review of the literature. In Social Science and Medicine 59, 2004.
[5] A Joint Study by the WHO and the WTO Secretariat: "WTO Agreements and Public Health", 2002
[6] WHO, David Woodward, Nick Drager, Robert Beaglehole and Debra Lipson: "Globalization, global public goods and health"
[7] Center for Global Health and Economic Development: http://cghed.ei.columbia.edu/

learn more effectively, work more efficiently, parent more supportively and become more productive members of their communities.

For individuals and families, health brings the capacity for personal development and economic security in the future. Health is the basis for job productivity, the capacity to learn in school, and the capability to grow intellectually, physically, and emotionally. In economic terms, health and education are the two cornerstones of human capital[8].

3.2.4 Linkages health/ other sectors

Ensuring that services meet the needs and expectations of the people depends on national governments setting the rules for the entire health system. Besides essential drugs and medical supplies, there are several other critical resources, including qualified health personnel, well-equipped facilities, and fair financing whether through insurance coverage or affordable public sector provision[9].

The need to regulate the private sector typically increases as competing suppliers enter the market. Governments need to act to prevent any adverse effects and channel any gains to benefit health. Greater, not less, regulation has accompanied more open markets in financial services and telecommunications, and this will be essential for health services as well.

Even if countries choose not to liberalize trade in the health sector, measures in other sectors can be relevant to health: for example, education commitments that affect the training of, and thus the scope of employment possibilities for, medical and health professionals; or commitments leading to improved transport and communication systems; or commitments in environmental or financial services. On a more general level, income effects generated by a more liberal trading environment can have positive effects on health through a variety of channels, such as increased government resources available for public health measures or increased household incomes spent on personal health care.

Apart from GATS, others WTO multilateral trade agreements that have particularly important implications for public health. One is the agreement on the Trade-Related Aspects of Intellectual Property Rights (TRIPS), which sets the minimum standards of protection for intellectual property rights including patents, copyrights, trademarks, and industrial designs.

Though intended to strengthen incentives to create new knowledge, it may make patented drugs less affordable and accessible to developing countries. It also raises issues concerning the desirability of treating knowledge as a global public good and of decreasing the knowledge gap between countries, while skewing research, e.g. for pharmaceutical development, towards the health needs of the rich rather than the poor.

Questions are also being asked about the “patentability” of traditional medicines that have been in the public domain for centuries as well as of new drugs, diagnostic agents, and therapies resulting from the application of biotechnology.

Another agreement, on the application of Sanitary and Phytosanitary Measures (SPS), affects national policies for food safety. To apply measures more restrictive than the international standards set by the Codex Alimentarius Commission, a country must show

[8] WHO: Macroeconomics and health, investing in health for macroeconomic development. Report of the Commission on Macroeconomics and Health, 2001.
[9] A Joint Study by the WHO and the WTO Secretariat: “WTO Agreements and Public Health”, 2002

scientific evidence of risks to health, although the Agreement does allow countries to implement provisional measures in the absence of conclusive scientific evidence.

On the other hand, the Agreement on Technical Barriers to Trade (TBT) has implications for the production, labeling, packaging, and quality standards of pharmaceuticals, biological agents, foodstuffs, and other consumer products. The TBT Agreement stipulates that products must be compared to "like" products without considering production methods or practices, and this creates a potential bias against the adoption of health and safety regulations if they add to production costs.

Other policies have a huge impact on health such as access to water and quality. Still two fifths of the world's population does not have adequate sanitation. As a result, more than two million children die from sanitation-related diseases every year.

An adequate financial environment must exist for consumption of health services to grow robustly. Current health insurance markets in the developing world are quite meager but, similar to health services, appear set to grow concomitantly with public demand and ability to pay[10].

3.2.5 Regulations, their importance: elements to consider

Depending on appropriate regulatory conditions, trade liberalization can contribute to enhancing quality and efficiency of supplies and/or increasing foreign exchange earnings[11]. For example, hospitals financed by foreign investors can provide certain services not previously available. In a few developing countries, such as Thailand and Jordan, the health sector serves as a regional supply centre that attracts foreign patients who can contribute to domestic income and employment.

Governments can require private health providers to provide a certain amount of free care to the poor, or tax the facilities and dedicate the revenue to support public health services. To limit any reduction in health service capacity for disadvantaged groups, a government may require private hospitals, for example, to:

- reserve a minimum percentage of beds for free treatment to the needy;
- offer some basic medical services in remote rural areas; or
- train a higher number of staff than required for their own purposes.

Different types of rules can affect directly the offer and demand of health services[12]:

-Prescriptions for qualifications and licenses for health professionals to provide qualitative criteria for services and integrity of professionals;

-Prescriptions for the approval of institutional suppliers such as clinics and hospitals as well as restrictions related to products and services, professionals and services are authorized to supply;

[10] Ian S. Mutchnik, David T. Stern and Cheryl A. Moyer: Trading health services across borders, GATS, markets and caveats. Global Health, GATS and markets, January 2005.
[11] A Joint Study by the WHO and the WTO Secretariat: "WTO Agreements and Public Health", 2002
[12] OMC, Conseil du Commerce des Services: Services de santé et services sociaux. Note d'information du Secrétariat, S/C/W/50. 18 Septembre 1998.

-Rules and practices insurance and compulsory insurance regimes – public and private-;
-Measures of control and incentives for services supplies in all regions and to all kind of population;
-Direct supply of minimal services to poor people.

3.3 EXAMPLES OF WTO MEMBERS

Different countries were chosen for the purpose of this study to make a benchmark for the following reasons:

	Neighborhood	New WTO member	Transition countries	Advanced countries
Jordan	X	X		X
Saudi Arabia	X	X		
Turkey	X			X
Ukraine		X	X	
United Arab Emirates	X			X
Vietnam		X	X	

Date of accession of the benchmarked countries:

	Date of accession
Jordan	11 April 2000
Saudi Arabia	11 December 2005
Turkey	26 march 1995
Ukraine	16 May 2008
United Arab Emirates	10 April 1996
Vietnam	11 January 2007

Source: WTO

3.3.1 Health services

3.3.1.1. 1st Sub-sector: Hospital services

The first sub-sector on health pertains to "hospital services". All the benchmarked countries did commitments under this chapter with the exception of the United Arab Emirates

- Under **Mode 1**, most of the countries made no commitments, due to lack of feasibility.
- Under **Mode 2**, all the benchmarked countries did full commitments ("none")
- Under **Mode 3**, limitations to market access are foreign equity limitation, the form of companies and requirements on qualifications of the owners.

  Review of limitations defined on market access under Mode 3:

	HOSPITAL SERVICES
MODE 3	**Limitations on market access**
Jordan	-One of the owners must be a physician except in a public limited company -51% foreign equity limitation until 1.1.2004 then 100%
Saudi Arabia	-None except subject the formation of a company between a foreign hospital company and a licensed Saudi medical professional
Turkey	-Permission from the ministry of Health
Ukraine	-None except professional qualification requirements according to Ukrainian legislation
Vietnam	-Through the establishment of 100% foreign equity, JV with Vietnamese partners or through business cooperation contract -Minimum capital: USD 20 million for a hospital, USD 2 million for polyclinic and USD 200,000 for a specialty unit

- Under **Mode 4**, national positions are mainly "unbound except as indicated in the horizontal section". Jordan required that "at least 3/4 of physicians in any hospital or nursing or convalescent home must be Jordanian nationals and at least 1/2 of all staff must be Jordanian nationals".

3.3.1.2. 2nd Sub-sector: Other human health services

The second sub-sector on health pertains to "other human health services". Among the benchmarked countries, Turkey, Vietnam and the United Arab Emirates did not take any commitments.

- Under **Mode 1**, only Jordan made full commitments ("none"), Saudi Arabia and Ukraine put "unbound".

- Under **Mode 2**, the 3 countries –Jordan, Saudi Arabia and Ukraine made full commitments.

- Under **Mode 3**, limitations defined are more or less equivalent to those under the previous sub-sectors. Limitations are summarized in the following chart:

MODE 3	OTHER HUMAN HEALTH SERVICES Limitations on market access
Jordan	-Laboratory directors must be Jordanian nationals -51% foreign equity limitation until 1.1.2004 then 100%
Saudi Arabia	-None except subject the formation of a company between a foreign health company and a licensed Saudi medical professional
Ukraine	-None except professional qualification requirements according to Ukrainian legislation

- Under **Mode 4**, national positions of Saudi Arabia and Ukraine are "unbound except as indicated in the horizontal section". Jordan required that "laboratory directors must be Jordanian nationals".

3.3.1.3. 3rd Sub-sector: Social services

The third sub-sector on health pertains to "social services". Among the benchmarked countries, only Jordan and Ukraine did commitments and Jordan limited the scope of social services to "nursing houses, convalescent homes and rehabilitation centers".

- Under **Modes 1 and 2**, both countries did full commitments ("none").

- Under **Mode 3**, Ukraine did full commitment ("none") while Jordan required:

  -One of the owners must be a physician except in a public limited company

  -51% foreign equity limitation until 1.1.2004 then 100%

- Under **Mode 4**, Ukraine defined "unbound except as indicated in the horizontal section". Jordan required that "at least 3/4 of physicians in any hospital or nursing or convalescent home must be Jordanian nationals and at least 1/2 of all staff must be Jordanian nationals".

3.3.2 Business services linked to health

3.3.2.1. 1st Sub-sector: Medical and dental services

Turkey and the United Arab Emirates did no do any commitments under this chapter. Note that Jordan excluded 'dental services'.

- Under **Modes 1 and 2**, all the countries who defined commitments, put no limitations to market access (Jordan, Saudi Arabia, Ukraine and Vietnam).

- Under **Mode 3**, restrictions on market access are related to nationality, form of companies, qualifications and foreign equity. The positions of other benchmarked countries are summarized in the chart below:

	MEDICAL AND DENTAL SERVICES
MODE 3	**Limitations on market access**
Jordan	-Access is restricted to physicians and they must be Jordanian nationals
Saudi Arabia	-Foreign equity limitation to 75%
Ukraine	-None except professional qualification requirements according to Ukrainian legislation
Vietnam	-Through the establishment of 100% foreign equity, JV with Vietnamese partners or through business cooperation contract -Minimum capital: USD 20 million for a hospital, USD 2 million for polyclinic and USD 200,000 for a specialty unit

- Under **Mode 4**, the most common position is "unbound except as indicated in the horizontal section". Jordan added "physicians must be Jordanian nationals".

3.3.2.2. 2nd Sub-sector: veterinary services

Among the benchmarked countries, Jordan and Turkey did not take any commitments under this chapter.

- Under **Mode 1 and 2**, Saudi Arabia, Ukraine, the United Arab Emirates and Vietnam countries put no limitations to market access ("none").

- Under **Mode 3**, only Ukraine and the United Arab Emirates did not define any limitation to market access ("none"). Saudi Arabia required 75% foreign equity limitations and Vietnam put the following limitation on market access: "access is limited to natural

persons exclusively for the conduct of private professional practice and under the authorization of the veterinarian authorities.

- Under **Mode 4**, the common position is “unbound except as indicated in the horizontal section”.

3.3.2.3. 3rd Sub-sector: Services provided by midwives, nurses, physiotherapists and para-medical personnel

Among the benchmarked countries, only Jordan and Ukraine took specific commitments under this chapter.

- Under **Mode 1**, Jordan did full commitment (“none”) while Ukraine did not take any (“unbound”).

- Under **Mode 2**, both countries did not put any limitations on market access.

- Under **Mode 3**, Jordan did not define any limitation to market access (“none”). Ukraine puts “none except professional qualifications requirements according to the Ukrainian legislation”

- Under **Mode 4**, the common position is “unbound except as indicated in the horizontal section”.

3.3.2.4. 4th Sub-sector: Other

Only Jordan defined a position under the chapter ”other” and included “pharmacists”.

- Under **Mode 1 and 2**, Jordan did full commitment (“none”)

- Under **Mode 3**, Jordan puts the following limitation on market access:

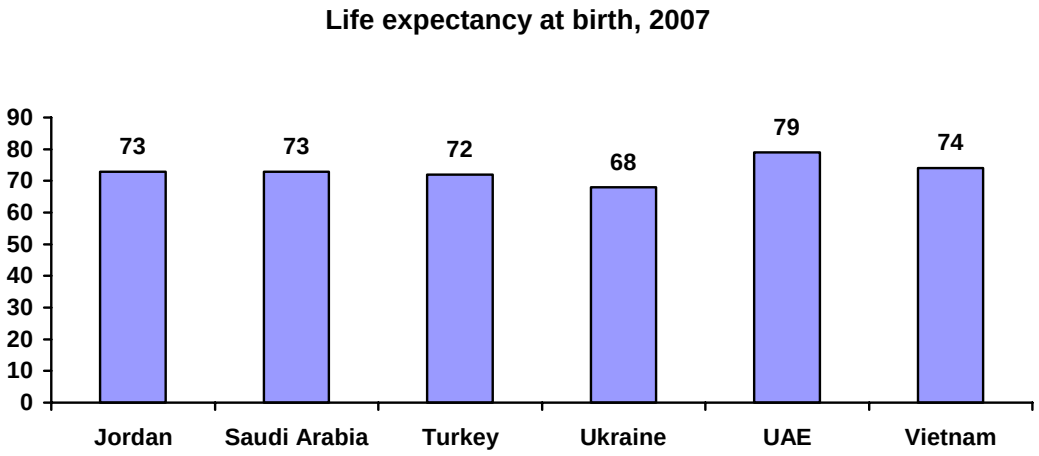
- Access restricted to pharmacists as natural persons or in general partnership. Only one outlet per pharmacist is allowed. Pharmacists must be Jordanian nationals.

- Under **Mode 4**, the Jordanian position is “unbound except as indicated in the horizontal section and physicians must be Jordanian nationals”.

3.3.3. State of play of the health sector in the benchmarked countries

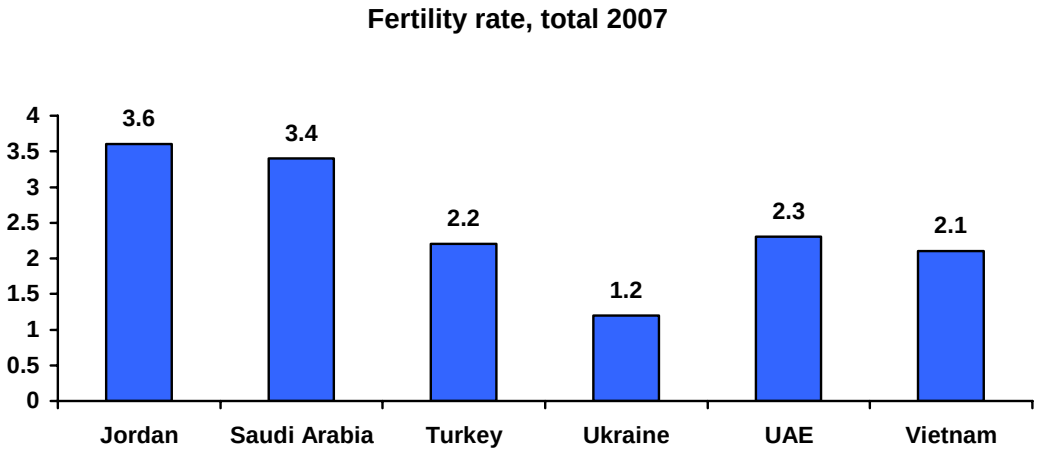
- **Data**

Among the benchmarked countries, the highest rate of life expectancy is in the United Arab Emirates where it is at 79 years, followed by Vietnam (74 years).



Source: World Bank

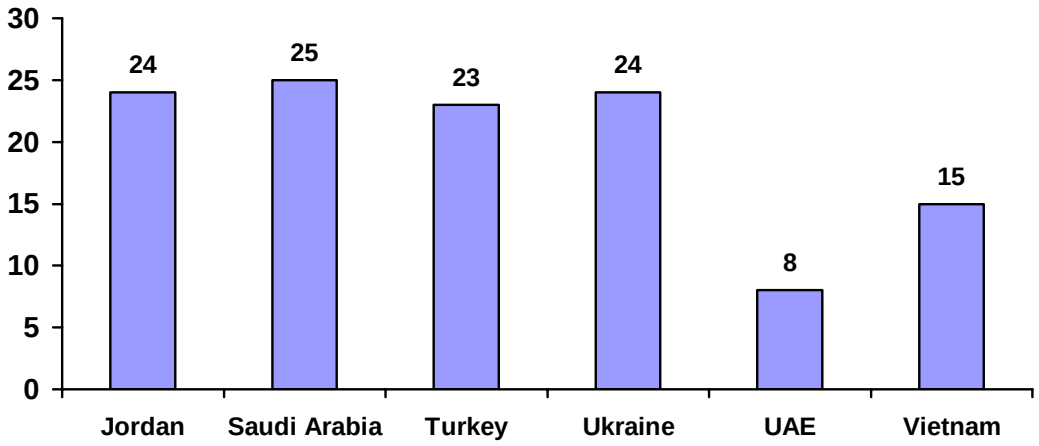
The highest fertility rate are in Jordan (3.6 children per woman) and Saudi Arabia (3.4) and the smallest are in Ukraine (1.2) and Vietnam (2.1).



Source: World Bank

The mortality rate of children under the age of 5 is still relatively high in Saudi Arabia and Jordan – respectively 25 and 24 per 1,000 -. The United Arab Emirates have the lowest rate with only 8 per 1,000.

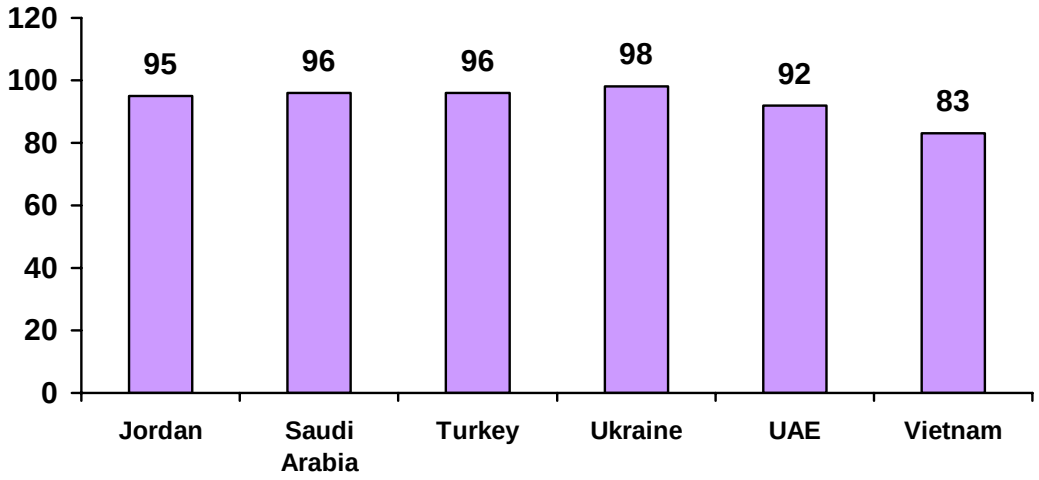
Mortality rate, under 5 (per 1,000), 2007



Source: World Bank

All around the world, immunization campaigns were launched to fight measles and a large majority of children are immune against this disease: 98% of them in Ukraine. The lowest data is in Vietnam with 83% of children immunized.

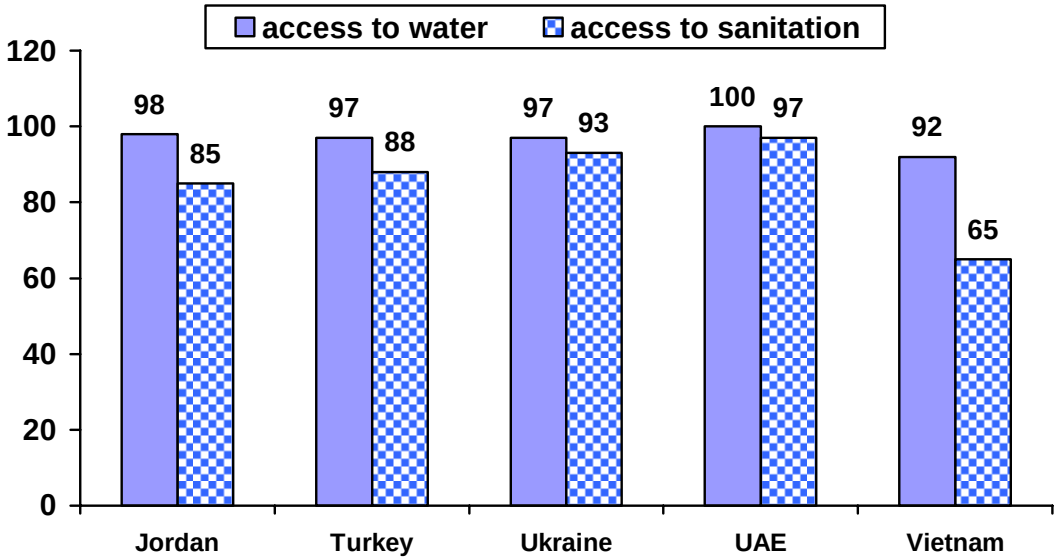
Immunization, measles (% of children ages 12-23 months), 2007



Source: World Bank

Access to water and sanitation is a major issue in many countries and impacts health of people. The highest access to those infrastructures is in the United Arab Emirates (100% of the population have access to improved drinking water sources and 97% to improved sanitation), second best being Ukraine.

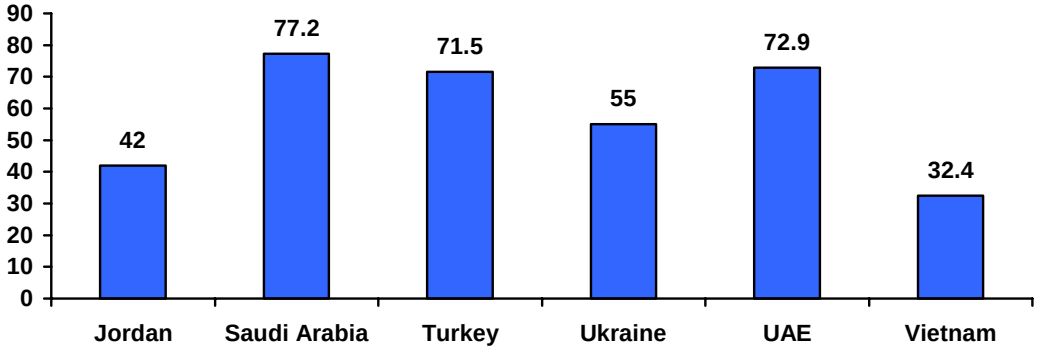
Population with sustainable access to improved drinking water sources and sustainable access to improved sanitation (%), 2006



Source: WHO, Data non available for Saudi Arabia

The governmental participation as part of the total expenditure on health is the highest in Saudi Arabia, the United Arab Emirates and Turkey.

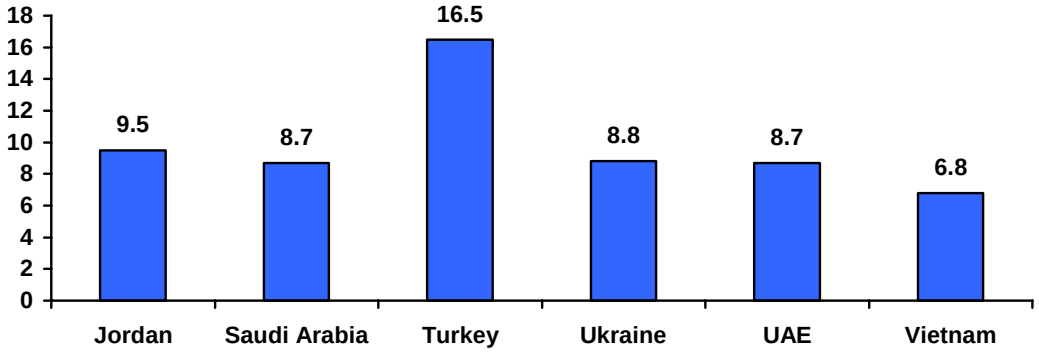
General government expenditure on health as percentage of total expenditure on health, 2006



Source: WHO

Health represents 16.5% of the State budget in Turkey, 9.5% in Jordan, 8.8% in Ukraine and 8.7% in the United Arab Emirates or in Saudi Arabia.

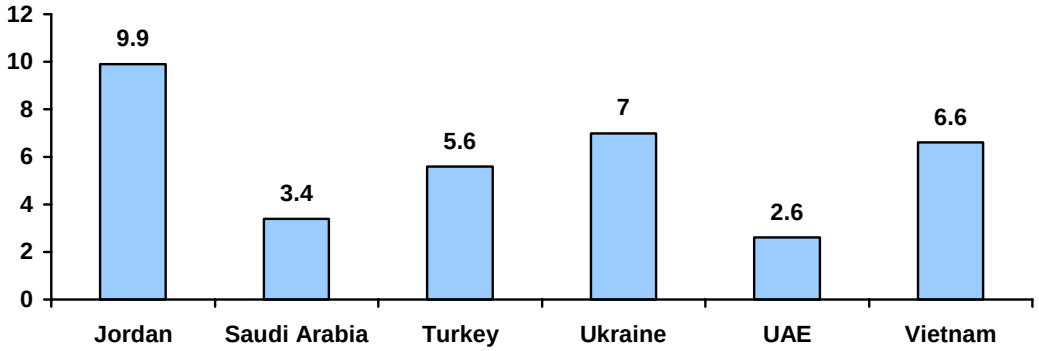
General government expenditure on health as percentage of total government expenditure, 2006



Source: WHO

It is in Jordan that the health expenditure as percentage of GDP is the highest reaching 9.9%.

Total expenditure on health as percentage of gross domestic product, 2006



Source: WHO

3.3.4 GATS commitments on health versus services efficiency

The direct impact of the WTO accession is not that clear, as most of the benchmarked countries have entered the WTO within the last 4 years.

The health system in Jordan includes the Ministry of Health, Royal Medical Services, public university hospitals, the private sector and the international and charitable sector, including UNRWA[13]. The MOH has 23 hospitals with 3229 beds (37%). Jordan has made great strides since the beginning of the 1990s toward becoming the medical center of the Arab world. In this context, it has launched massive investment programs to upgrade and modernize public hospitals and medical schools[14].It has, at the same time, created incentives for national and foreign private investment in the health sector. As a result of this strategy, 11 new private hospitals have started operations; most of them have state of- the-art technology, including computerized links with prestigious health centers in Europe and North America.

Saudi Arabia has witnessed a massive improvement in socioeconomic development in the past 30 years, with startling progress having been made in health, education, housing and the environment. As hospitals consume 60% of the Ministry of Health budget, there are moves to give hospitals independence[15] and guide the role of the Ministry of Health towards policy setting, purchasing equipments, monitoring and evaluation. The total number of physicians (including the dentists) is 22643[16]. 61% of health force is expatriates.

The United Arab Emirates (UAE) is a small, high-income country with rich natural resources. The country enjoys peace, stability and actively seeks and facilitates investment from all over the world. Health delivery is provided by six different federated authorities and nine regionalized medical districts[17]. The primary health care services are decentralized to the regions, with some powers and autonomy. 26 hospitals and 106 primary health care centres provide a comprehensive health care to all people. The decentralization has improved the quality of care.

In Turkey, health care is provided by public, semi-public, private and philanthropic organizations, including the Ministry of Health (MOH), universities, the Ministry of Defense and private health professionals. Provincial Health Directorates (81 provinces) are responsible for service planning and provision at provincial level. Primary health care is provided through health centres, health posts, Maternal and Child Health (MCH) and Family Planning (FP) centres and tuberculosis dispensaries; municipalities play a role in environmental health and sanitation. The health financing system is also fragmented, with four explicit publicly funded insurance schemes as well as direct supply subsidies to MOH health facilities[18]. Despite this, approximately 10-20% of the population is not covered by any of the existing statutory insurance schemes. There are 26.39 hospital beds/10 000 population. Until 2005, the MOH owned and operated 56.12% of hospitals and 55.09% of beds.

[13] Country Cooperation Strategy for WHO and Jordan 2003-2007.
[14] WHO, David Benavides: Trade policy and export of health services- a development perspective
[15] WHO, Country Cooperation Strategy at Glance, Saudi Arabia, May 2007.
[16] Saudi Ministry of Health: http://www.moh.gov.sa/
[17] WHO, Country Cooperation Strategy at Glance, May 2007
[18] WHO, Country Cooperation Strategy at Glance, Turkey, March 2007

4. THE IRAQI HEALTH SECTOR

4.1 ECONOMIC, SOCIAL AND REGULATORY ENVIRONMENT

Iraq Key Indicators:

Population: 28,9 million
GDP in 2006(PPP): USD 94.1 billion[19]
GDP real growth rate 2007: 5% (est.)
GDP per capita (PPP) 2007: USD 3,600 (est.)
GDP, Composition by sector:
-Agriculture: 5%
-Industry: 68%
-Services: 27%

The past five years have been extremely difficult for the Iraqi economy, but during the course of 2007 some encouraging signs of improvement began to emerge. The level of violence came down, and this was accompanied by a number of successes on the economic front.

The authorities responded with a policy package including exchange rate appreciation, monetary tightening, and fiscal discipline. These policies, together with measures to reduce fuel shortages, brought inflation down to less than 5% by December 2007. Core inflation—which excludes fuel and transportation prices—fell to about 12% in 2007, from 32% in 2006.

Despite the achievements in 2007, much remains to be done to consolidate macroeconomic stability and put the economy on a higher growth path. Public confidence remains very low and violence is still widespread. Corruption and governance problems continue to impede the functioning of the public and private sectors.

4.2 THE IRAQI HEALTH SECTOR

4.2.1 Background

Last few years, Iraq faced difficulties such as destructions of rehabilitated health care facilities, dramatic increase of the number of casualties against civilians, triggering the capabilities of emergency medical services and tensions to ensure continuity of basic health services[20].

In 2006, Iraq remained on the list of the world's top 60 countries with highest "Under 5 Infant and Maternal Mortality Rates".

[19] CIA World Fact book
[20] Word Health Organization: Annual Report Iraq 2006

The WHO considers that "most of the 1,700 public hospitals and health centers still need rebuilding, while management systems and structures require strengthening and organization to improve access to essential quality drugs and medical supplies. Iraq is also facing a range of immediate and severe environmental problems, including hazardous waste contamination, an issue exacerbated by poor infrastructure in the Iraqi water sector".

It has also to be noted that the destruction or lack of maintenance of basic infrastructures such as water systems, sewage or electricity have major impact on Iraqi's population health.

4.2.2 Data

Iraq counts for 1,989 primary health centers in 2008. There were 34,000 Iraqi physicians registered before 2003 invasion[21]. In 2008 they were 19 334 doctors depending on the Ministry of Health and 41 975 nurses[22]. There are 4 medical colleges in Baghdad and 15 in Iraq.

Iraq, health indicators:

	2000	2005	2007
Life expectancy at birth (years)	58	59	60
Fertility rate	5.1	4.5	4.3
Adolescent fertility rate (births per 1,000 women ages 15-19)	44	39	37
Births attended by skilled health staff (% of total)	72	89	n.a.
Malnutrition prevalence, weight for age (% of children under 5)	13	7	n.a.
Immunization, measles (% of children ages 12-23 months)	87	69	69

Source: World Bank

[21] Brookings: Iraq index, June 25, 2009.
[22] Ministry of Health, Republic of Iraq: Annual Report 2008

Estimated availability of essential services, % population with access to specific service February 2009:

Service	February 2009
Sewage	20%
Water (access to potable water)	45%
Electricity (+12 hours of power per day)	50%
Public health	30%
Trash (population services)	45%

Source: Brookings: Iraq index, June 25, 2009

Health system in Iraq is centralized and hospital-based and need major reform. Health represents 5.8% of the State budget.

Some communicable diseases have reemerged[23]. Diarrhoeal diseases, acute respiratory infections, measles, mumps, typhoid fever and Leishmaniasis have substantially increased since 1990. Other diseases including malaria, cholera and diphtheria have been declining. Infectious diseases due to disruption of health services pose a potential threat.

Maternal and child health - 45% of births occur outside health institutions. Maternal and child health services represent a major function of primary health care (PHC) but half of referral institutions lack resources and staff therefore, maternal mortality is extremely high. Diarrhoeal and upper respiratory infections are high among children.

Social determinants of health such as environmental conditions have deteriorated, the damage to safe water and sewage networks has created a very serious source of water-borne disease. Air pollution, inadequate solid wastes management and waste management and chemical safety are serious health hazards. Malnutrition and poverty due to conflict are major health concerns.

4.2.3 Recent projects developed to improve the health sector

Immediately after the 2003 war, the Coalition Provisional Authority (CPA) had the dominant role in health, with USAID also having an active part. At present a large number of international, bilateral, multilateral organizations and nongovernmental organizations (NGOs) are assisting the health sector in Iraq, such as the Ministry of Health, other associated ministries, UN Health Cluster – WHO, UNICEF, UNFPA, WFP, UNDP, IOM, UNIFEM, UNIDO and UNEP- the World Bank, USAID, DFID, the Japanese Government and other key donors including international and national NGOs, most of which are coordinated by the NGO Coordination Committee.

[23] WHO, Country Cooperation Strategy at Glance, Iraq, May 2007

The partners are helping the Ministry of Health and the country in the development of its health system, rehabilitation of hospitals and health care facilities, emergency services, immunization and diseases control, prevention and monitoring of HIV/AIDS, mental health, maternal and obstetric care, training of health personnel, purchasing and distribution network of medicines and medical supplies, drinking water quality testing and monitoring, food safety.

4.2.4 Legal framework

The legislation related to Health in Iraq is the following:

1. Health Law No. 89 year 1981
2. Food system Law No. 29 year 1982
3. Ministry of health Law No. 10 year 1983
4. Law on private hospitals establishment No. 25 year 1984
5. Physicians association Law No. 81 year 1984
6. Dentists association Law No. 46 year 1987
7. Pharmacists association Law No. 112 year 1966
8. Law on practicing pharmacist profession No. 40 year 1970
9. Law on national committee for health and profession safety No. 6 year 1988
10. Law on protecting and improving environment No. 3 year 1979
11. Law on protection against ionic radiation No. 99 year 1980
12. Psychiatric health Law No. 1 year 2005
13. Law on public medical clinics No. 89 1986
14. System of practicing health professions No. 11 year 1962
15. Health quarantine Law No. 6 year 1992

4.2.5 Role of the Iraqi private sector

The development of a private health sector should be seen as giving opportunities to Iraqi practitioners – physicians, etc.- to come back in Iraq and to invest in the sector. It will promote new techniques and methods and attract new patients in need.

5. RECOMMENDATIONS ON IRAQI POSITIONS ON GATS/ HEALTH SERVICES NEGOTIATIONS

5.1 RECOMMENDATIONS ON HEALTH SECTOR UNDER GATS

Commitments to health are needed (i.e. a commitment in WTO terms of "none"—see below—represents the type of commitment necessary to free up investment potential in Iraq) in areas where further investment is required from trading partners such as large companies, or where access to high quality services is required by other sectors.

The chart below has several parts to it that are necessary to understand for ease of reading[24]:

- Modes:

Mode 1/ Cross-border supply
Mode 2/ Consumption abroad
Mode 3/ Commercial presence
Mode 4/ Presence of natural persons

- Commitment Categories:

"Unbound": no commitment is defined. It means that the country can change anytime its domestic policy.
"None": it means that the country opens at the multilateral level its service to foreign competition without any limitation

Important options when scheduling GATS commitments include the opportunity to phase-in obligations over time (e.g. 5-10 years), thereby giving both foreign and domestic investors sufficient time to prepare and adapt, while fully indicating the seriousness of government policy intentions. Other possible GATS options include limiting the number of foreign suppliers, adding joint-venture requirements, foreign-equity limitations, training requirements, etc.

[24] For a full explanation on reading the services charts expanded across five sectors see: Lewarne, Stephen, Iraq Services Liberalization Study, USAID/Iraq IZDIHAR, November 2007

Position defined by the sub-committee on Health services, August 19, 2009

Sector or Sub-sector	Limitations on Market Access	Limitations on National Treatment	Additional commitments
IRAQ 8 Health Related and Social Services			
A. Hospital services CPC 9311	1) None 2) None 3) None except: -Foreign hospitals should recruit a minimum of 50% Iraqi nationals 4) Unbound except as indicated in the horizontal section	1) None 2) None 3) None except: -Foreign hospitals should recruit a minimum of 50% Iraqi nationals -Foreign hospitals should train their Iraqi national staff 4) Unbound except as indicated in the horizontal section	
B. Other human health services CPC 9319	1) None 2) None 3) Unbound 4) Unbound except as indicated in the horizontal section	1) None 2) None 3) Unbound 4) Unbound except as indicated in the horizontal section	
C. Social services CPC 933	1) None	1) None	

	2) None 3) None except: -Foreign companies should recruit a minimum of 50% Iraqi nationals 4) Unbound except as indicated in the horizontal section	2) None 3) None except: -Foreign companies should recruit a minimum of 50% Iraqi nationals -Foreign companies should train their Iraqi national staff 4) Unbound except as indicated in the horizontal section	
D. Other -Marketing and distribution (wholesale and retail) of pharmaceuticals and medical equipments	1) Unbound 2) None 3) None except: -Foreign companies should recruit a minimum of 75% Iraqi nationals 4) Unbound except as indicated in the horizontal section	1) Unbound 2) None 3) None except: -Foreign companies should recruit a minimum of 75% Iraqi nationals -Foreign companies should train their Iraqi national staff 4) Unbound except as indicated in the horizontal section	
IRAQ <u>1 Business services</u>			
A.h. Medical and dental services CPC 9312	1) None 2) None 3) None, except dentists and preventive services: unbound 4) Unbound except as indicated in the horizontal section	1) None 2) None 3) None, except dentists and preventive services: unbound 4) Unbound except as indicated in the horizontal section	

A.i. Veterinary services CPC 932	1) Unbound 2) Unbound 3) Unbound 4) Unbound	1) Unbound 2) Unbound 3) Unbound 4) Unbound	
A.j. Services provided by midwives, nurses, physiotherapists and paramedical personnel CPC 93191	1) Unbound 2) None 3) None, except: -Nurses, midwives, physiotherapists and paramedical personnel have to be fully employed by a public or private structure in Iraq. 4) Unbound except as indicated in the horizontal section	1) Unbound 2) None 3) None, except: -Nurses, midwives, physiotherapists and paramedical personnel have to be fully employed by a public or private structure in Iraq. 4) Unbound except as indicated in the horizontal section	
A.k. Other	1) Unbound 2) Unbound 3) Unbound 4) Unbound	1) Unbound 2) Unbound 3) Unbound 4) Unbound	

Representatives from the Ministry of Trade, Ministry of Health and Ministry of Environment are part of the Sub-Committee on Health Services

5.2 PRECONDITIONS TO HEALTH LIBERALIZATION

5.2.1 Liberalization and regulation

It is of utmost importance to get the legal support for all changes that are expected to take place as a consequence of free trade of health services. In this respect, it is necessary to develop and update health legislation covering[25]:

- conditions for licensing foreign health professionals;
- barriers that limit entry in the health professions, if any;
- the ethics of health and medical practice;
- health and medical responsibility; and
- norms and standards of quality in health care.

In addition to the general regulatory environment, of importance are those regulations that are directly pertinent to health, as health care tends to be amongst (if not the) most heavily regulated sector of a nations' economy. The plethora of regulations in health care may therefore make the impact of FDI, or its possibilities, differ considerably from other sectors. For example, regulation concerning standards of health care, establishments, professional accreditation and mutual recognition, cross-subsidization policies, pro-poor regulations, restrictions on corporate hospitals, conditions placed upon profits, reinvestment and resource transfer to the government, the role of professional bodies and the powers they exercise, medico-legal liability issues and so forth[26].

Fears are frequently expressed that the free trade of health services may lead to an inequitable two-tier health service delivery system with high-tech care for the rich segments of the population and limited quality care for the poor. Laws and constitutions entrust governments with the duty to protect equity in access to health care and to avoid any geographical, financial, or cultural barriers to that access. Governments are also concerned about the respect of ethical values underlying the provision of health care. Such values often shape the regulation of health care and medical practice, the codes of conduct of health professionals, and the bill of rights of patients.

5.2.2 Linkages between health liberalization and other trade policy issues

Four specific agreements have important implications for public health[27]. The agreement on the trade related aspects of intellectual property rights sets minimum standards of protection for intellectual property rights including patents, copyrights, trademarks, and

[25] WHO, Belgacem Sabri: The Eastern Mediterranean Region Perspective
[26] Richard D Smith: Foreign Direct Investment and trade in health services: a review of the literature. In Social Science and Medicine 59, 2004.
[27] Nick Drager: Making trade work for Public Health, WHO, 1999

industrial designs. The agreement has implications for the production and access to drugs and vaccines.

The agreement on the application of sanitary and phytosanitary measures affects national policies for food safety. For countries to restrict trade they have to show scientific evidence of risks to health, though the agreement does allow countries to implement provisional measures in the absence of available scientific evidence.

The agreement on technical barriers to trade has implications for the production, labeling, packaging, and quality standards of pharmaceuticals, biological agents, and foodstuffs.

The lack of sanitation and drinkable water, and the presence of pollution cause many illnesses in developing countries and hinder their development. To liberalize also environmental services is of interest of developing countries.

5.2.3 Other issues to be considered

Liberalized trade in health-related services should lead to an optimal balance between preventive and curative services[28].

Involvement of both private industry and civil society is important to ensure that liberalization of health-related services promotes participatory health policy towards achieving national goals.

Improving access and affordability of health-related services should be a goal of liberalization of trade in health-related services.

[28] Nick Drager and David P. Fidler: GATS and health related services. WHO Trade and Health notes, February 2004

6. IMPACT OF GATS/ HEALTH SERVICES IN IRAQ

6.1 ECONOMIC IMPACT

Increased trade in health services could open the sector to increased competition, bringing with it needed technology and management, and for some countries, increased export earnings. It could also deepen current inequities in access and promote the migration of skilled health professionals from already under serviced areas.

Depending on appropriate regulatory conditions, trade liberalization can contribute to enhancing quality and efficiency of supplies and/or increasing foreign exchange earnings. For example, hospitals financed by foreign investors can provide certain services not previously available. New hospitals can also offer attractive employment alternatives for health professionals who might otherwise leave the country[29].

The possible benefits resulting from health care internationalization and trade liberalization can be directed toward public health objectives in various ways. The revenue generated through the treatment of foreign patients may be used, for instance, to upgrade facilities that benefit the resident population as well.

Further trade liberalization of the health sector can lead to improved health systems in developing countries by providing additional financial resources, exposing health professionals from developing countries to new techniques, and providing them access to higher qualifications[30]. Also, improvements can follow from introducing innovative management systems in developing countries, upgrading the quality of the health treatments they can provide, especially in the rural areas, and strengthening foreign and domestic competition.

The most direct beneficiaries of liberalization are the households[31] who can afford the services offered by foreign suppliers. Private providers do generally offer services which were not offered by the public sector.

Inflow of foreign capital in certain parts of the health system may reduce the burden on government resources and allow the public sector to reallocate its resources toward the patients with less ability to pay.

[29] A Joint Study by the WHO and the WTO Secretariat: “WTO Agreements and Public Health”, 2002
[30] WHO, Simonetta Zarrilli: Identifying a trade negotiating agenda
[31] North West Institute, Chantal Blouin: International trade in health services and the GATS, May 2006.

6.2 SOCIAL IMPACT

A potential benefit of foreign direct investment is that it may provide high-quality services that are not currently available domestically. In the absence of government regulation, these services are, however, likely to be only available to those who can afford it.

Trade in health services carries risks and in some cases, has exacerbated existing problems with access and equity of health services and financing, especially for poor people in developing countries. For example, a rise in the "brain-drain" of health professionals leaving low-income countries to work in higher income countries, can increase health personnel shortages in developing countries, leading to problems in access to and quality of health services. It also results in losses to governments with respect to the investment made on training health professionals[32]. Many qualified health professionals migrate to seek better living standards, career opportunities, and higher remuneration which they cannot get in their home countries[33]. Hence, the migration of health personnel could alleviate the shortage in the more developed countries.

For-profit private, foreign- invested hospitals tend to target more lucrative markets and disregard the needs of remote regions and disadvantaged groups. In addition, by offering more attractive employment conditions, they exacerbate shortages of skilled staff in public facilities, on which the poor rely.

The quality of care may suffer if the home country loses the best health personnel. The migration of health personnel creates higher costs for the home countries, since in most of them education of health personnel is mainly subsidized by public funds and requires a large investment.

In terms of direct health care provision, similarly, the private sector's profit-making imperative makes it of limited relevance to those sections of society, which are unable to pay for its services, even though it is they who need the extra investment, most. Yet private investment in health care is not simply an irrelevance to poor people. In many countries, as noted above, an expanding private sector will draw personnel away from public health systems and exacerbate shortages of trained and qualified staff. Often it is the most skilled staff that makes the move to the private sector, lowering the overall quality of personnel in the public health system[34].

[32] A Joint Study by the WHO and the WTO Secretariat: "WTO Agreements and Public Health", 2002
[33] WHO, Wattana J. Janjaroen and Siripen Supakankunti: International Trade in health services in the Millenium – the case of Thailand
[34] Dr B Ekbal: GATS and the health sector

6.3 ENVIRONMENTAL IMPACT

There is no environmental impact of health services liberalization. It is the contrary, if environmental services – sewages etc.- as well as other infrastructures such as water and electricity are improved, they impact the health level of the population.

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World Trade Organization: http://www.wto.org

Declaration on the TRIPS Agreement and public health
Adopted on 14 November 2001

1. We recognize the gravity of the public health problems afflicting many developing and least-developed countries, especially those resulting from HIV/AIDS, tuberculosis, malaria and other epidemics.

2. We stress the need for the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) to be part of the wider national and international action to address these problems.

3. We recognize that intellectual property protection is important for the development of new medicines. We also recognize the concerns about its effects on prices.

4. We agree that the TRIPS Agreement does not and should not prevent Members from taking measures to protect public health. Accordingly, while reiterating our commitment to the TRIPS Agreement, we affirm that the Agreement can and should be interpreted and implemented in a manner supportive of WTO Members' right to protect public health and, in particular, to promote access to medicines for all.

In this connection, we reaffirm the right of WTO Members to use, to the full, the provisions in the TRIPS Agreement, which provide flexibility for this purpose.

5. Accordingly and in the light of paragraph 4 above, while maintaining our commitments in the TRIPS Agreement, we recognize that these flexibilities include:

(a) In applying the customary rules of interpretation of public international law, each provision of the TRIPS Agreement shall be read in the light of the object and purpose of the Agreement as expressed, in particular, in its objectives and principles.

(b) Each Member has the right to grant compulsory licenses and the freedom to determine the grounds upon which such licenses are granted.

(c) Each Member has the right to determine what constitutes a national emergency or other circumstances of extreme urgency, it being understood that public health crises, including those relating to HIV/AIDS, tuberculosis, malaria and other epidemics, can represent a national emergency or other circumstances of extreme urgency.

(d) The effect of the provisions in the TRIPS Agreement that are relevant to the exhaustion of intellectual property rights is to leave each Member free to establish its own regime for such exhaustion without challenge, subject to the MFN and national treatment provisions of Articles 3 and 4.

6. We recognize that WTO Members with insufficient or no manufacturing capacities in the pharmaceutical sector could face difficulties in making effective use of compulsory licensing under the TRIPS Agreement. We instruct the Council for TRIPS to find an

expeditious solution to this problem and to report to the General Council before the end of 2002.

7. We reaffirm the commitment of developed-country Members to provide incentives to their enterprises and institutions to promote and encourage technology transfer to least-developed country Members pursuant to Article 66.2. We also agree that the least developed country Members will not be obliged, with respect to pharmaceutical products, to implement or apply Sections 5 and 7 of Part II of the TRIPS Agreement or to enforce rights provided for under these Sections until 1 January 2016, without prejudice to the right of least-developed country Members to seek other extensions of the transition periods as provided for in Article 66.1 of the TRIPS Agreement. We instruct the Council for TRIPS to take the necessary action to give effect to this pursuant to Article 66.1 of the TRIPS Agreement.

Annex: Commitments of benchmarked countries

JORDAN

Sector / Sub-Sector	Limitations on Market Access	Limitations on National Treatment	Additional Commitments
08. Health Related and Social Services			
A. Hospital Services (CPC 9311) C. Social Services (CPC 933). Specifically, these are nursing homes, convalescent homes, rehabilitation centers	1) None 2) None 3) One of the owners must be a physician except in a public limited company. Commercial presence (in mode 3) is subject to 51% foreign equity limitation. Starting no later than 1 January 2004 , 100% foreign equity will be permitted. 4) Unbound, except as indicated in the horizontal section. At least ¾ of physicians in any hospital or nursing or convalescent homes must be Jordanian nationals; at least ½ of all staff must be Jordanian nationals.	1) None 2) None 3) None 4) Unbound, except as indicated in the horizontal section.	

B. Other Human Health Services, specifically medical labs (CPC 93199)	1) None 2) None 3) None, except lab. director must be a Jordanian national. Commercial presence (in mode 3) is subject to 51% foreign equity limitation. Starting no later than 1 January 2004 , 100% foreign equity will be permitted. 4) Unbound, except as indicated in the horizontal section. Lab. director must be a Jordanian national.	1) None 2) None 3) None 4) Unbound, except as indicated in the horizontal section.	
j) Services Provided by Midwives, Nurses, Physiotherapists (CPC 93191)	1) None 2) None 3) None 4) Unbound, except as indicated in the horizontal section.	1) None 2) None 3) None 4) Unbound, except as indicated in the horizontal section.	
k) Other Pharmacists	1) None 2) None 3) Access restricted to pharmacists as natural persons or in general	1) None 2) None 3) None	

	partnership. Only one outlet per pharmacist allowed. Pharmacists must be Jordanian nationals. 4) Unbound, except as indicated in the horizontal section. Pharmacists must be Jordanian nationals.	4) Unbound, except as indicated in the horizontal section.	

SAUDI ARABIA

Sector / Sub-Sector	Limitations on Market Access	Limitations on National Treatment	Additional Commitments
08. Health Related and Social Services			
A. Hospital Services (CPC 9311)	1) Unbound* 2) None 3) None, except subject to formation of a company between a foreign hospital company and a licensed Saudi medical professional 4) Unbound, except as indicated in the horizontal section	1) Unbound* 2) None 3) None 4) Unbound, except as indicated in the horizontal section	
B. Other Human Health	1) Unbound*	1) Unbound*	

Services (CPC 9319, except 93191))	2) None 3) None, except subject to formation of a company between a foreign hospital company and a licensed Saudi medical professional 4) Unbound, except as indicated in the horizontal section	2) None 3) None 4) Unbound, except as indicated in the horizontal section	
h.Medical and dental services (CPC 9312) i.Veterinary services (CPC 93201)	1) None 2) None 3) Foreign equity limited to 75% 4) Unbound, except as indicated in the horizontal section	1) None 2) None 3) None 4) Unbound, except as indicated in the horizontal section	

VIETNAM

Sector / Sub-Sector	Limitations on Market Access	Limitations on National Treatment	Additional Commitments
08. Health Related and Social Services			
8. HEALTH RELATED AND SOCIAL SERVICES A.Hospital services (CPC 9311) B.Medical and dental services (CPC 9312)	1) None 2) None 3) Foreign service suppliers are permitted to provide services through the establishment of 100% foreign-invested hospital, joint venture with Vietnamese partners or through business cooperation contract. The minimum investment capital for a commercial presence in hospital services must be at least US$20 million for a hospital, US$2 million for a policlinic unit and US$200,000 for a specialty unit. 4) Unbound, except as indicated in the horizontal section	1) None 2) None 3) None 4) Unbound, except as indicated in the horizontal section	
i) Veterinary Services (CPC	1) None	1) None	#8 Excluding keeping

932) #8	2) None 3) Access is granted to natural persons exclusively for the conduct of private professional practice and under the authorization by the veterinary authorities. 4) Unbound, except as indicated in the horizontal section	2) None 3) None 4) Unbound, except as indicated in the horizontal section	micro-organism strain for veterinary.

UNITED ARAB EMIRATES

Sector / Sub-Sector	Limitations on Market Access	Limitations on National Treatment	Additional Commitments
01.A Professional Services			
i) Veterinary services (CPC - 9320)	1) None 2) None 3) None 4) Unbound, except as indicated in the horizontal section	1) None 2) None 3) None, except as indicated in the horizontal section 4) Unbound, except as indicated in the horizontal section	

TURKEY

Sector / Sub-Sector	Limitations on Market Access	Limitations on National Treatment	Additional Commitments
08. Health Related and Social Services			
A.Hospital services (CPC 9311)	1) Unbound *9 2) None 3) Foreigners may establish private hospitals with the permission of Ministry of Health. 4) Unbound	1) None 2) None 3) None 4) Unbound	*9) Unbound due to the lack of technical feasibility.