Asia-Pacific
Economic Cooperation

Synthesis and Proceedings of the APEC Seminar on Trade in Health Services

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Group on Services
Committee on Trade and Investment

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Produced by
Bureau of International Health Cooperation
Department of Health
Republic of the Philippines
Bldg. 3, G/F, San Lazaro Compound
Rizal Avenue, Sta. Cruz, Manila
Philippines 1003
(632) 743-83-01 local 1338

For
Asia Pacific Economic Cooperation Secretariat
35 Heng Mui Keng Terrace
Singapore 119616
Tel: (65) 68919 600
Fax: (65) 68919 690
Email: info@apec.org
Website: www.apec.org

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LIST OF ACRONYMS USED

APEC	Asia-Pacific Economic Cooperation
BIHC	Bureau of International Health Cooperation
CSR	Corporate Social Responsibility
DOH	Department of Health
DOT	Department of Tourism
DRG	Diagnosis-related Group
GATS	General Agreement on Trade in Services
GP	General Practitioner
ICT	Information and Communication Technology
IMF	International Monetary Fund
MSITS	Manual on Statistics of International Trade in Services
OECD	Organisation for Economic Cooperation and Development
TCR	Translational and Clinical Research
TWG	Technical Working Group
UNCTAD	United Nations Conference on Trade and Development
UNSD	United Nations Statistics Division
UNWTO	United Nations World Tourism Organization
UP	University of the Philippines
WHO	World Health Organization
WTO	World Trade Organization

PART I. SEMINAR SYNTHESIS

The seminar focused on three key challenges facing Asia-Pacific Economic Cooperation (APEC) members in terms of cooperation on trade in health services;

- Harnessing the linkages among the different modes of supplying trade in health services;
- Fostering trade and cooperation among APEC economies in the area of health services; and,
- Ensuring the integration of national health systems (public and private), in order for trade in health services to benefit marginalized sectors of society.

The seminar adopted the General Agreement on Trade in Services' (GATS) four modes of supplying services across borders (i.e. cross-border trade, consumption abroad, commercial presence, and temporary movement of natural persons) as a framework.

The first day was devoted to presentations and discussions on the factors that drive or facilitate trade in health services; as well as those that impede them. Group workshops were undertaken to discuss these factors as they relate to participants' economies. [Table 3. Summary of Workshop Discussions on Day 1 (February 9, 2010)].

The second day focused on presentations and discussions of issues on trade in health services. The main issues identified were as follows:

Table1. Trade in Health Services Issues, by mode of supply
Summary of Workshop in Day 2 (February 10, 2010)

Mode	Issues
• Cross-border trade	Opportunities in e-Health, connectivity (ICT infrastructure), standards, data privacy, malpractice & liability
• Consumption abroad	Insurance portability, quality assurance, standards, accreditation, malpractice & liability
• Commercial presence	Regulation, ease of doing business, taxation & incentives, investment facilitation, litigation, transparency
• Temporary movement	Mutual Recognition Agreements (MRAs), competencies of health professionals, cooperation agreements
• Issues across modes	Availability of cross-country data and information, promoting equity and efficiency

Across four modes, the participants identified two important issues:

(1) How to cooperate in ensuring the availability of reliable data and information on trade in health services; and,

(2) How can economies promote the economic benefits of trade in health services AND at the same time contribute to equitable health systems that provide quality, affordable and accessible health services to all.

The participants then decided on cooperation projects that they would recommend for APEC to pursue. These projects are the following:

Table 2: Proposed Projects for APEC Cooperation (based on results of Workshop on Day 2, February 10, 2010)

Proposed Project 1	
Title	Promoting investments in trade-related health care services among APEC members
Objectives	• To document and disseminate specific experiences with respect to investments in health care services, from the perspective of both originating countries (and investor-groups) and destination countries; • To identify and discuss lessons from these country-case studies and develop a toolkit for investments in trade in health care services; and, • To promote investments in trade in health services among APEC members
Actions required	(1) Develop specific country-case studies on foreign direct investments in health care services (focus on Malaysia, Singapore, Philippines, Thailand, US, and Australia); (2) Organize APEC seminar/workshop for disseminating case study results; based on workshop discussions, develop frameworks for promoting investments, highlighting: opportunities and drivers, barriers and risks, and facilitation mechanisms. (3) Develop and disseminate the investment tool kit.
Time-frame	Short-term (1-2 years)

Proposed Project 2	
Title	Enhancing cooperation on eHealth among APEC members
Objectives	• To document and disseminate specific country experiences with respect eHealth applications; • To identify and discuss how these lessons can help promote cross-border trade in eHealth among APEC members; and, • To develop and disseminate a toolkit for expanding cooperation in eHealth among APEC members.
Actions required	(1) Develop specific country-case studies on eHealth applications (focus on Australia, US, Korea, Chinese Taipei, Japan, Malaysia, and Thailand) (2) Organize APEC seminar/workshop for disseminating country-case study results; discuss how to promote cross-border eHealth applications; and develop frameworks for promoting cooperation in eHealth. (3) Develop and disseminate the eHealth tool kit.
Time-frame	Short-term (1-2 years)

Proposed Project 3	
Title	Enhancing cooperation on Data Collection and Dissemination on Trade in Health Services among APEC members
Objectives	• To promote a more relevant and uniform classification system and definition for Trade in Health Services among APEC members • To help ensure the availability of up-to-date, reliable, and comparable data on Trade in Health Services among APEC members
Actions required	(1) Convene a technical working group (TWG) to work on Trade in Health Services Statistics, consistent with current international efforts on improving the Manual of Statistics on International Trade in Services (MSITS)[1] (2) Conduct research on existing systems, mechanisms, and capabilities for measuring trade in health services among APEC members (3) Organize workshop to disseminate and discuss research results; develop framework for data collection and dissemination, including specific strategies and mechanisms (4) Implement data framework in specific countries; evaluate results; and revise data framework design (5) Conduct capacity building and advocacy programs among relevant stakeholders
Time-frame	Short-term (1-2 years)

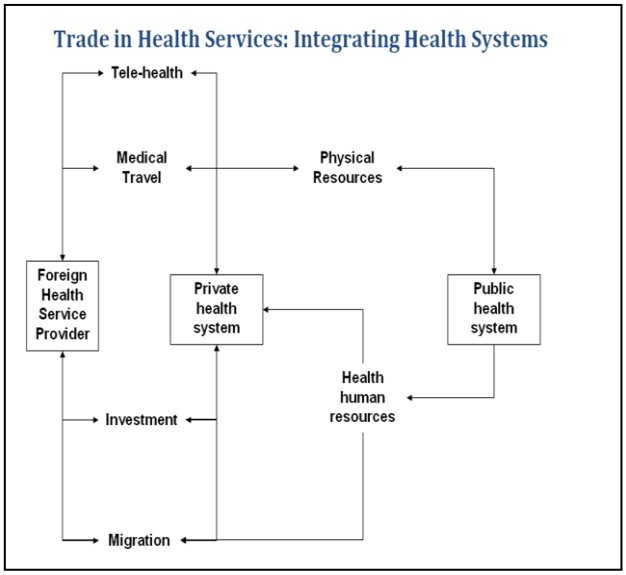
Proposed Project 4	
Title	Enhancing trade negotiating capacities of health ministries of APEC members
Objectives	• To promote more active participation of health ministries in trade in health services negotiations • To ensure commitments on trade in health services reflect overall health goals and priorities of APEC members • To promote cooperation on trade in health services among APEC members
Actions required	(1) Conduct training needs analysis on current capacities and gaps of health ministries, with respect to negotiations on trade in health services (2) Design a capacity building intervention, including case studies of experience of specific countries on trade in health services negotiations; link with initiatives of other multilateral/regional institutions (e.g. World Health Organization) (3) Conduct capacity building activity (4) Document results and disseminate lessons learned from capacity building activity
Time-frame	Short-term (1-2 years)

[1] A task force was established to elaborate the statistical requirements of the General Agreement on Trade in Services (GATS). It is convened by the Organisation for Economic Cooperation and Development (OECD), and consists of Eurostat, International Monetary Fund (IMF), the United Nations Conference on Trade and development (UNCTAD), the United Nations Statistics Division (UNSD), the United Nations World Tourism Organization (UNWTO) and the World Trade Organization (WTO).

Proposed Project 5	
Title	Promoting Networking activities among APEC members in the area of insurance portability
Objectives	• To promote a more detailed understanding of the importance of insurance portability, its attendant processes and mechanics, as well as important requisites (e.g. quality standards, etc.) • To share lessons learned by countries who have been successful in attaining international portability of insurance for their health services, focusing on the specific approaches and strategies they used • To help promote international portability of insurance among APEC members
Actions required	(1) Analyze status of insurance portability across APEC members (2) Conduct specific case studies of countries which were able to achieve international portability of insurance for health services (3) Organize and hold a fora for discussing results of country-case studies (4) Disseminate lessons learned from country-case studies
Time-frame	Short-term (1-2 years)

On the third day, discussions focused on the need to ensure that the pursuit of opportunities in trade in health services contributes to the availability of accessible, affordable, quality health care for all, especially the disadvantaged sectors of society.

Based on the discussions and the presentations, there are clear linkages between trade in health services and private health systems; but the linkage with the public health sector seems to be weak. Moreover, there is even danger of a one-way flow of resources and expertise from the public health system to the traded health services. Examples of these include (a) movement of public health workers and professionals to foreign countries, (b) transfer of public health workers and professionals to the private sector, which in turn is pursuing foreign markets, and (c) government specialty hospitals attending to foreign patients. (ref. Trade in Health Services and the Public Health System)



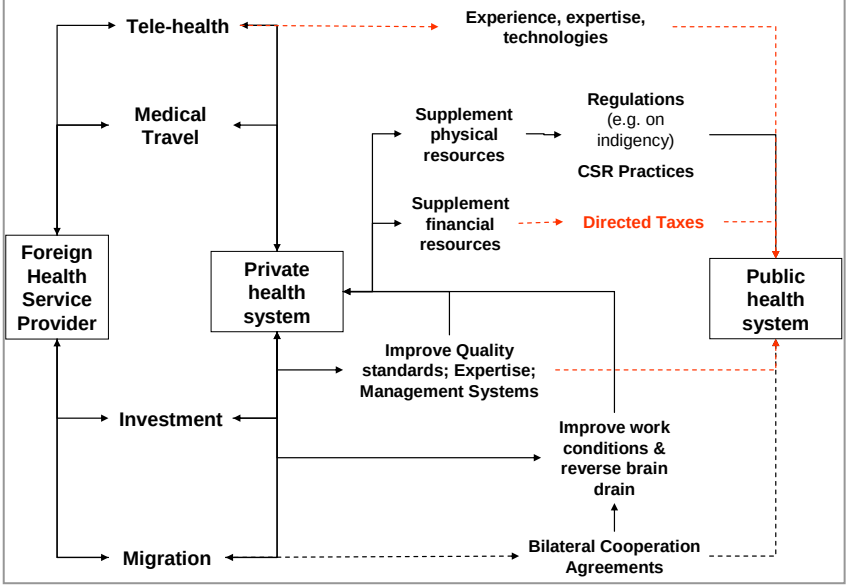
The discussions emphasized the need to enhance the linkages that promote the flow of resources from trade in health services to the public health sector. This

can be done either indirectly by going through the private health sector or directly by accessing resources from trade in health services.

Examples of how this can be done include: (ref. Trade in Health Services: Integrating Health Systems)

- harnessing the opportunities from eHealth in order to provide for greater access to geographically-remote, poor communities that are physically difficult to access;
- supplementing public health resources by taxing private facilities[2] that cater to foreign markets, or by requiring them to provide subsidized services to the poor (indigency requirements);
- pursuing bilateral cooperation agreements on movement of health human resources, that require recruiting foreign countries or institutions to supplement resources of sending (local) institutions, to be used to maintain a steady pool of workers and professionals under training or to prepare for the re-integration of returning health workers; and,
- providing mechanisms for transferring improvements attained in service delivery quality and standards from the private sector (e.g. internationally-accredited health facilities) to the public sector, including management systems and clinical expertise.

Fig. 2. Trade in Health Services: Integrating Health Systems



As a highlight of the seminar, the participants issued a Joint Statement on Health Services and Trade (Annex 26. Joint Statement on Health Services and Trade). This Statement, presented by the participants to the Philippine Government, will provide a framework to the cooperation projects recommended as a result of the Seminar.

[2] Though this is currently being done in APEC members, the proceeds are remitted to the general budget and are not specifically directed to the public health sector. The public health system will then have to compete for resources with other sectors through the regular budget appropriation process. A tax that can be directed specifically to the health sector can be a more certain way of establishing direct linkage between public health and trade in health services.

Table 3. Summary of Workshop Discussions on Day 1 (February 9, 2010)

	Common Examples	Impeding factors	Facilitating factors	Opportunities	Mitigating risks	Impacts on Health System
Mode 1	Tele-prescription; Tele-consultation (video-conferencing); Tele-pathology; Medical transcription; Tele-education	- Lack of domestic capital - Lack of capacity by domestic human resources - Lack of standards - Lack of legal framework to address professional liability	- Reliable digital infrastructure - Effective regulations - Verification process (electronic signature) - Standards and accreditation - Human resource capability	- Additional income & capital flows - Technology transfer - Capacity-building for providers - Linkages (networking among institutions) - Competition provides opportunity to improve standards and develop safeguards - Access to technology for the underserved population	- Make tele-health services available to all - Subsidize price for lower income	
Mode 2	Medical; Surgical; Diagnostic; Dental; Traditional	(possible solutions in parentheses) - language (have training/liaison officer) - cost/price transparency (develop common source of information) - travel (group travel; assessment; Med. Evac.) - border control issues (medical visa/visa on arrival) - accuracy of info (telemedicine; presence of local GP) - expectations on level of quality (medical procedures; accreditation; service STAR rating) - liabilities & risks - service collaborations in product development - access to market		- Inter-economy collaboration, e.g. comparability of data & statistics; readiness for international markets	- Continuous assessment of present and long-term expectations - Government to assume responsibility (governance) - Government & Private sector Partnership	- <u>Positive:</u> Increase income per capita; enlarge economy; increase job opportunities; increase clinical patient data; opportunity to develop skills - <u>Negative:</u> Brain drain; demand for equality by foreign patients; increase in cost of healthcare; loss of income (for sending countries); loss of local skills

	Common Examples	Impeding factors	Facilitating factors	Opportunities	Mitigating risks	Impacts on Health System
Mode 3	- Equity in hospitals, clinics	- Foreign equity limitations - Legal limits on the practice of profession by foreigners	- Investment incentives	- Infusion of foreign capital - Transfer of technology and knowledge	- Make health services available to all - Subsidize price for lower income	
Mode 4	Doctors; Nurses; Physical therapists; Occupational therapists; Medica; technologists; Radiology technologists; Technicians; bio med engineers; physicists	- Accreditation & standards - Language - Transportation cost - Immigration requirements - Close family ties	- Better remuneration - Access to technology & telecommunications - Job opportunities - Presence of family members who can provide support	Multiplier effect of remittances	- Improve standards - Strengthen health ministries - Assessing quality of health care - Encouraging other stakeholders to invest more and to generate more employment	Positive impact in health system of receiving countries Costly for sending countries – health workers leave upon being trained; difficulty to develop core group of professional health workers

PART II. SEMINAR PROCEEDINGS

A. Introduction

1. The Philippines proposed to hold the Seminar on Trade in Health Services among APEC members, with the twin objectives of: (a) understanding the factors that facilitate or inhibit health services trade and investments (including sound regulation); and (b) sharing of experiences on the opportunities and risks in trade in health services liberalization, especially its impact on national health systems. Thailand, Indonesia and Singapore co-sponsored the seminar, which was undertaken under the APEC Working Group on Services.

2. The Seminar was in response to current challenges faced by economies of ensuring that pursuit of opportunities in trade in health services (e.g. medical tourism, tele-health, migration of health professionals, foreign investment in health facilities, etc.) are undertaken within the context of public health objectives, i.e. that it does not harm public health objectives and even contribute to the delivery of accessible, affordable, effective, quality health services to disadvantaged sectors of the population.

3. There were 31 participants and 11 speakers and resource persons, three convenors, and five members of the Seminar Secretariat. The economies represented (by the participants and the speakers/resource persons) were: Australia, Brunei Darussalam, People's republic of China, Malaysia, Philippines, Singapore, Thailand, the United States, and Vietnam. There were also two presenters from the World Health Organization (WHO). A list of the participants and resource persons can be found in Annex 1.

4. The three-day Seminar was designed, to include presentations, discussions, site visits and workshops. It adopted the General Agreement on Trade in Services' (GATS) four modes of supplying services across borders (i.e. cross-border trade, consumption abroad, commercial presence, and temporary movement of natural persons) as framework. A copy of the program is attached as Annex 2.

B. Opening Ceremonies

5. The Seminar opened as Hon. Edsel T. Custodio, Undersecretary for International Economic Relations and Philippine Senior APEC Official of the Department of Foreign Affairs (DFA), and Dr. Paulyn Jean Rosell-Ubial, Assistant Secretary, Field Implementation Management Office of the Department of Health (DOH), respectively extended warm welcome to the participants. (Annex 3. Welcome Remarks)

6. Ms. Maylene Beltran, Director of the Bureau of International Health Cooperation (BIHC) of the DOH then gave a presentation that detailed the

context of the seminar; its overall objectives; the methodologies that will be employed; the presentations, discussions, workshops and site visits that will be held; and, the final outputs to be expected. (Annex 4. APEC Seminar on Trade in Health Services: An Overview)

C. Seminar Presentations

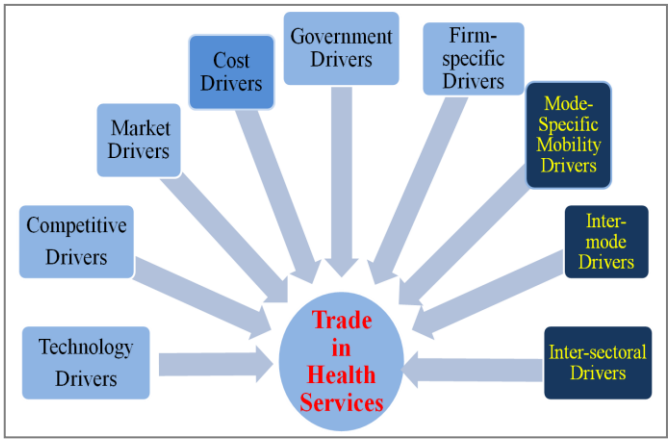
i. Day One: Factors that Facilitate or Impede Trade in Health Services

7. The first Seminar presentation was given by Ms. Catherina Maria Elisabeth Timmermans, Technical Officer for IPR and Trade and Health of the South-East Asia Regional Office and Western Pacific Regional Office of the WHO. She gave an overview of the GATS framework as it applies to trade in health services. (Annex 5. GATS & trade in health services: a brief overview)

8. Ms. Timmermans next presented the WHO's diagnostic toolkit, including experiences in using it. The toolkit aims to help countries enhance the linkage between trade in health services and their public health objectives. The toolkit was borne out of *World Health Assembly (WHA) Resolution 59.26: International Trade and Health*, which calls on WHO Member States to ensure that health and trade are balanced, and:

    a. to promote intersectoral dialogue and establish coordination mechanisms;
    b. to adopt policies, laws and regulations to harness the opportunities and address the challenges;
    c. to generate coherence in trade/health policies;
    d. to develop capacity to track and analyse the impact of trade and trade agreements on health.

    To pursue the objectives of the resolution, countries need to undertake comprehensive national assessment of issues at the interface of trade and health. This requires knowledge about international trade agreements and how they operate; as well as an analytical framework to systematically analyze the health implications of trade. (Annex 6. A diagnostic tool on trade and health: background, update and experiences).



9. Dr. Amir Mahmood, Associate Professor in Economics and International Business of the University of Newcastle, Australia, discussed the

health services linkages among different modes of supply and across sectors. He elaborated on the characteristics of services (e.g. intangibility, non-storability and inseparability of healthcare services) and linked these with their implications on how health services are supplied (e.g. four modes of supplying services under the GATS). He also discussed the drivers that impede or facilitate trade and investments; dissecting and analyzing these drivers according to the following categories: technology, competitive, market, cost, government, and firm-specific. Prof. Mahmood also introduced the concept of mode-specific mobility drivers, inter-mode drivers, and inter-sectoral drivers.

Prof. Mahmood concluded by identifying the factors that will play crucial role in health services trade:

- Quality and quantum of human capital
- Services trade liberalisation and domestic reforms
- Changes in global/regional demand and responsiveness to change
- Market sector selection and resource deployment
- Exploitation of inter-mode and cross-sectoral linkages
- Emergence of efficient and value enhancing healthcare value chain involving inter-modal and cross-sectoral linkages

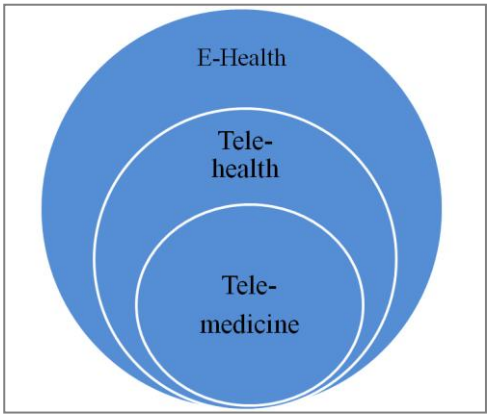
(Annex 7. Trade in Health Services: Linkages Across Modes and Sectors)

10. Prof. Mahmood then shared the experience of Australia in tele-health. As a useful starting-point, he distinguished between e-health, tele-health, and tele-medicine.

    a. E-Health: refers to the use of ICT in health sector for clinical, educational and administrative purposes, both at the local site and at a distance.

    b. Telehealth: refers to the application of ICT to provide (at a distance between two or locations) health-related activities such as: diagnostic and treatment services, educational and support services, organisation and management of health services.

    c. Telemedicine: refers to that subset of tele-health that deals with medical diagnostic and treatment services.



He cited the main drivers of tele-health as follows:

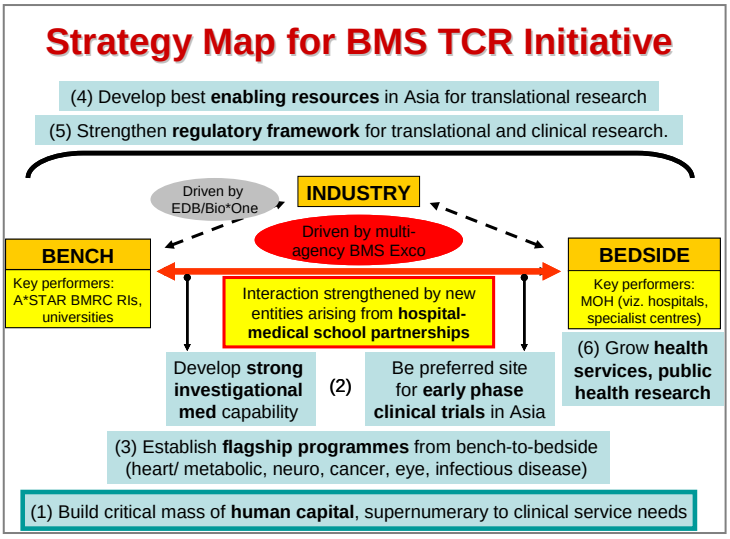
- Advances in telecommunications technologies
- Increased separability of services from their production process
- Declining costs of electronic delivery
- Increased awareness & ease of use
- Reliability of tele-health systems
- Availability of Information and Communication Technology (ICT) and medical infrastructure, resources, and competencies
- Resource deployment and market selection (medical transcription by India and the Philippines)

He also identified the risks involved in cross-border trade in tele-health services, as follows:

- Data transmission, confidentiality and information security
- Professional responsibility
- Patients' rights and consent
- Reimbursements/payments
- Liability for negligence and abandonment
- Potential for fraud and abuse
- Secure access concerns

(Annex 8. Challenges in Tele-Health & Cross-border Supply & the Australian Context)

11. An overview of Singapore's biomedical initiatives was given by Dr. Loke Wai Chiong, Director of the Health & Wellness Programme Office, Ministry of Health (Singapore). Dr. Chiong presented Singapore's experience in Translational and Clinical Research (TCR), tracing the development of the country's biomedical sciences initiative and revealing its strategy for TCR. He emphasized the need for developing a critical mass of human capital for TCR through:
    a. Attract outstanding clinician-scientists from overseas
    b. Encourage local clinicians to engage in clinical research
    c. Develop strong pipeline of clinician-scientists and clinician-investigators



In terms of strategy, Dr. Chiong enumerated Singapore's strategy as:

a. Build critical mass of **human capital**, supernumerary to clinical service needs
b. Be preferred site for **early phase clinical trials** in Asia; Develop **strong investigational medical** capability
c. Establish **flagship programmes** from bench-to-bedside (heart/ metabolic, neuro, cancer, eye, infectious disease)
d. Develop best **enabling resources** in Asia for translational research
e. Strengthen **regulatory framework** for translational and clinical research.
f. Grow **health services, public health research**

(Annex 9. Overview of Singapore's Biomedical Sciences Initiative)

12. The last presentation of the first day was given by Mr. Ruy Y. Moreno, Director for Operations-Private Sector of the National Competitiveness Council/PPP Task Force on Globally Competitive Philippine Service Industries (Committee on Health and Wellness). He highlighted the unique value propositions of the Philippines as a health and wellness tourism destination, including—among others—its location, English-speaking population, excellent medical professionals, high-quality medical facilities (internationally-accredited), cost competitive services, its unique care-giving culture, etc. (Annex 10. Medical Health Travel and Wellness: Case of the Philippines)

13. Group workshops were undertaken to discuss the factors that drive or facilitate trade in health services; as well as those the impede them. The workshops provided participants with the opportunity to discuss these factors as they relate to participants' economies. (Annex 11a. Workshop Guidelines; Annex 11b. Workshop Groupings)

ii. Day Two: Issues in Trade in Health Services

14. The second day of the seminar began with a brief review and summary of the discussions in the first day, presented by one of the Convenors, Mrs. Maria Cherry Lyn S. Rodolfo, Senior Economist at the University of Asia and the Pacific.

[Annex 12. APEC Seminar on Trade in Health Services: Highlights of Day 1 (February 9, 2010)]

15. Outputs of the two workshop discussion groups were then presented. (Table 3. Summary of Workshop Discussions on Day 1 (February 9, 2010)

16. Mr. Todd Nissen, Director for Services Trade Negotiations, Office of the United States Trade Representative, then presented on Borderless Medical Travel in APEC. He provided insights and statistics on the size of the US medical travel industry, highlighting factors that facilitate medical travel: quality assurance, networks facilitated by open investment, and E-health. On the other hand, Mr. Nissen enumerated the factors that hinder E-health: technical barriers at national and regional/global levels, such as non inter-operability of hardware, software and connectivity; lack of accepted standard in e-Health application; and harmonization of data privacy policies, including those involving use of third-party data storage (e.g. the cloud) (Annex 13. Borderless Medical Travel in APEC)

17. Dr. Veerachat Petpisit, Deputy Marketing Director, Bangkok Hospital Medical Center, then shared the experience of developing economy (Thailand) in securing international portability of insurance. He differentiated between health insurance products that provide global coverage (e.g. AIG, Cigna, CFE, Daman, Vanbreda, Lawton, etc.) and travel insurance (through assistance companies, e.g. International SOS, AXA Assistance, Mondial Assistance, CEGA, Euro-Center, etc.). He also highlighted the important points in the insurance business: Provider-Payer Business Agreements, Health Care Standards and Codes, Claims processes, and the Utilization Reviews. He ended by recommending the adoption of: common litigation place or standards, common standard of care, and a Common DRG (diagnosis-related group) system.

    [Annex 14. Insurance Portability and Trade Facilitation: Benefits, Barriers, Solutions and Agenda for APEC Cooperation (Experience of Developing Economies as Receiving Countries)]

18. Dr. Petpisit then shared Bangkok Hospital Medical Center's experiences in investing abroad. He advised on the need to understand the following: the market, the political and economical environment, and the business environment. In establishing foreign presence, the key issues he highlighted were: finding the right partner, understanding the taxation policies, income repatriation, medical licensing, local regulations and the regulatory authorities, and the extent of governmental support.

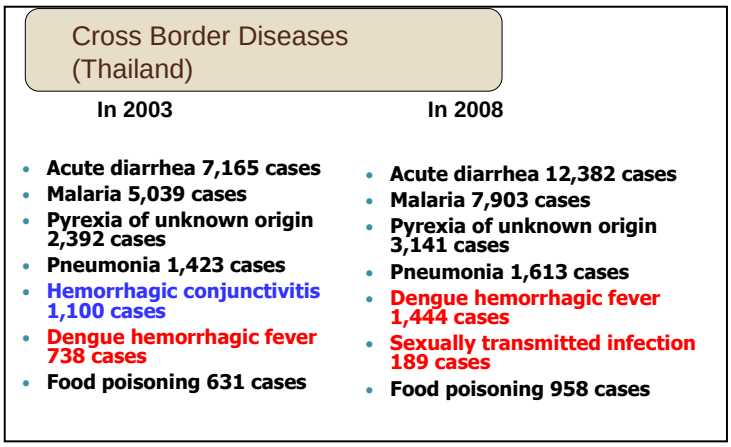
    [Annex 15. Experiences in Establishing Overseas Presence (Thailand)]

19. Dr. Songphan Singkaew, Policy and Plan Analyst, Senior Professional Level, Bureau of Policy and Strategy, Office of the Permanent Secretary, Ministry of Public Health (Thailand), discussed the impact of medical tourism on the public health system of Thailand. As a background, she mentioned that in 2008, Thailand had about 1.3 million foreign patients, of which 58.6% are medical travelers and general travelers and 41.4% are expatriates.

Dr. Singkaew emphasized the existence of two different health market segments: Private hospitals, which cater to foreign patients and a small number of well-off local customers; and Public health facilities that cater to local Thai patients. She discussed that medical tourism may reduce local Thais' access to health care services; and open the possibility of internal brain drain (i.e., doctors from government hospitals moving to private health institutions). She concluded that if brain drain does occur, this will affect primarily the medical specialists and not the General Practitioners (GP). While GPs from government hospitals may get the chance to work in a private hospital, only a few will be able to work as permanent employees. Thailand has strict regulations on public doctors joining the private sector; and specialists also find prestige in practicing in big government hospitals.

20. Dr. Singkaew also shared Thailand's experience in cross-border illnesses, especially as the country has a significant number of migrant workers. She noted the relatively higher incidence of sexually-transmitted diseases.

(Annex 16. Impact on Public Health and Policy Responses: A Case of Thailand)



21. Mr. Theo Seiler, Chief Executive Officer of the Asian Hospital and Medical Center, discussed the experience of Asian Hospital in terms of its impact on public health. Mr. Seiler argued that, in general, foreign investments contribute to public health by: (a) providing international expertise, (b) providing access to management resources, (c) generating new/more job opportunities, (d) reducing the "brain-drain" problem (e.g. nurses), (e) enhancing transfer of "know-how," and through all of these, (f) improving the public health situation.

He also highlighted some of the potential obstacles to attracting investments in Asia, including: red tape and corruption, the legal system, restrictions on capital flow (dividends, repatriation of capital), cross-border borrowings, taxes (income taxes, WHT, VAT, etc.), and tax audits (with unreasonable audit results).

In the Q&A portion, Dr. Anthony Calibo, Philippine Medical Tourism Program Manager and assigned at the Office for Special Concerns - DOH, added that corporate social responsibility (CSR) projects of private hospitals can also contribute to improving the public health situation; while Dr. Elmer Punzalan, Assistant Secretary of Health. Office for Special Concerns – DOH, cautioned

against generalizing comments on corruption and instead requested for information on specific corruption-related experiences so these can be addressed.

(Annex 17. Impact of Foreign Investments on Public Health: A Philippine example)

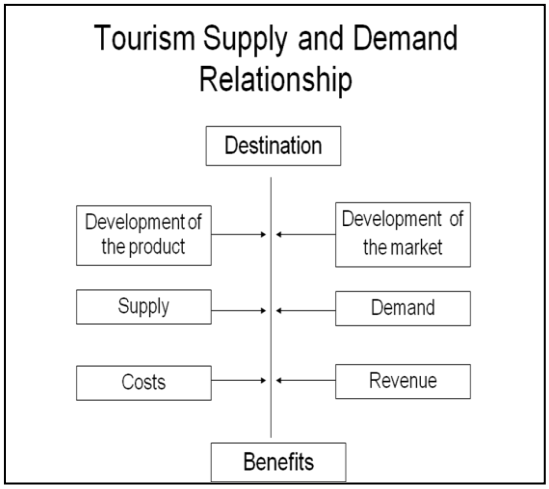
22. Atty. Genesis M. Adarlo, a Consultant of the DOH, then shared *"Experiences on Registration of Medical Tourism Ecozones in the Philippines."* He discussed the legal requirements for registering medical tourism zones and in availing of fiscal [e.g., four-year income tax holiday and payment of five percent gross income tax on income (in lieu of all national and local taxes), tax and duty-free importation of medical equipment] and non-fiscal incentives (employment of foreign nationals and Special Investor's Resident Visa).

    During the Q&A it was clarified that the incentives are only applied to the portion of the medical facility's operation relevant to (or its income derived from) servicing foreign patients. It was pointed-out that this may be the reason why a limited number of stakeholders have registered and availed of the incentives.

    (Annex 18. Experiences on Registration of Medical Tourism Ecozones in the Philippines)

23. Ms. Cynthia Lazo, Director of Wellness and Health, Philippines Department of Tourism, Philippines (DOT), shared the Philippines' experience in medical tourism and travel, including the country's unique positioning strategy. As a tool for measuring the size and contribution of health and wellness tourism, Director Lazo discussed a 2009 Taylor Nelson Sofres survey on medical tourism. This survey captured data covering nine (9) DOT-Accredited institutions and was administered by the DOT through a survey questionnaire.

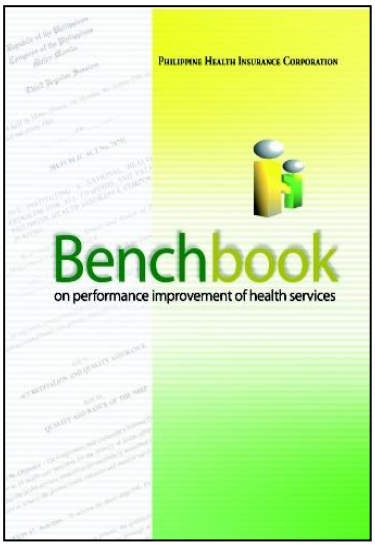
    Director Lazo also shared that the DOT and the National Statistics Office, with the support of the DOH, are embarking on a Survey of Tourism Establishments in the Philippines (STEP), which seeks to capture both demand-and supply-side information related to tourism (including medical tourism). Establishments to be covered include: those providing accommodation, transportation companies, restaurants, travel agencies, tour operators, tertiary hospitals for medical tourism, ambulatory clinics, spa, and ESL (English as Second Language) institutions.



(Annex 19. Trade in Health Services Statistics: Case of the Philippines)

24. Dr. Shirley Domingo, Vice President for Health Finance Policy Sector, Philippine Health Insurance Corporation (PhilHealth), then presented the Philippines' experience measuring the quality of health care services through accreditation of health care providers and facilities. She emphasized the importance of accreditation in promoting the following dimensions of quality in health services: safety, effectiveness, efficiency, appropriateness, accessibility, and consumer participation.

    Dr. Domingo shared PhilHealth's Benchbook, which contains indicators for quality in the following performance areas: patient rights and organizational ethics, patient care, leadership and management, human resource management, safe practice and environment, and performance improvement. She further shared that the indicators were developed through several consultative meetings, where the stakeholders themselves suggested indicators for each performance standard and criteria.



    [Annex 20. Measuring Quality of Health Care through Accreditation of Health Providers and Facilities Philippines)].

25. Dr. Kenneth G. Ronquillo, Director of the Health Human Resource Development Bureau of the DOH discussed the Philippines' experience in ASEAN Mutual Recognition Arrangements. He identified the following challenges in pursuing MRAs: reluctance on engaging in MRAs, non-familiarity with MRAs, lack of budgetary support by lead stakeholders, domestic laws and regulations are not updated to support MRAs, and collaboration among both public and private sectors still have to be institutionalized.

    (Annex 21. ASEAN Mutual Recognition Arrangements: The Philippine Experience)

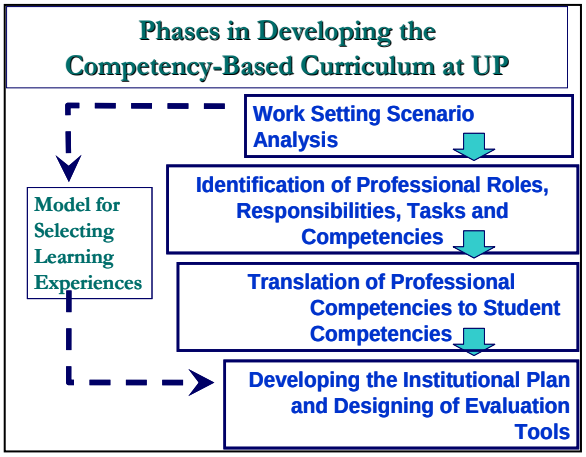
26. Ms. Kathleen Fritsch, Regional Adviser in Nursing for the WHO Office for the Western Pacific, then discussed the liberalization of practice of health professions. She presented both its positive and negative potential effects. For positive effects, she cited: opening of new employment opportunities, mitigating unemployment, contributing to economic growth, enhancing stability by providing employment, and increasing remittances. However, liberalization of practice of profession can also lead to: higher costs of health services and supplies, lower quality of services, health personnel shortages

due to increased migration and/or urban concentration, and reduced access to services by remote or vulnerable populations.

Ms. Fritsch discussed the core health professional competencies needed to address population health needs as follows:

- Epidemiology, health determinants, public health
- Communication (verbal and non-verbal—direct, indirect use)
- Inter-professional collaboration, team-building and teamwork
- Community partnerships, empowerment
- Accountability, organizational effectiveness
- Entry to practice safety in increasingly complex practice environments
- Continuous Quality improvement
- Cost analysis; health economics
- Cultural competence
- Health promotion, disease prevention
- Strategic planning, policy-making
- Mobilization, advocacy, coalition-building
- Evidence-base for practice

She then cited the example of the University of the Philippines (UP) in terms of developing competency-based curriculum.



(Annex 22. Liberalization of Professional Practice: Moving Forward Across Borders to Improve Access, Service Delivery, Population Health Outcomes)

27. Prof. Fely Marilyn Lorenzo, Director of the Institute of Health Policy and Development Studies of the National Institute of Health, UP College of Public Health, then shared how bilateral cooperation agreements can be used to attain the following policy goals in the temporary movement of health human resources: equity, effectiveness, efficiency, and security & safety. These cooperation agreements were or are being pursued according to the following principles: beneficial for source-country, destination and migrant individuals and families; efficient and effective use of investments; equity and access to opportunities and resources; efficient and transparent governance; and effective and acceptable collaboration mechanisms. Prof. Lorenzo emphasized that negotiations being pursued by the Philippines may even provide a model for bottom-up global development.

(Annex 23. Cooperation Agreements to Address Equity Issues: Case of the Philippines)

28. To better appreciate the challenges of linking opportunities in trade in health services to the delivery of accessible, affordable, effective public health services, the presentations were followed by visits to two hospital facilities: the Vicente Sotto Memorial Medical Center (a general, tertiary-level, government-owned hospital) and the privately-owned, internationally-accredited Chong Hua Hospital.

29. In the evening, Mr. Ceferino Rodolfo, one of the Convenors, discussed the guidelines for the evening workshops. The participants engaged in group discussions until 11:30 in the evening of the second day.

    (Annex 24. Workshop Guidelines for Day 2, February 10, 2010).

iii. Day Three: Synthesis and Recommendations

30. Mr. Ceferino Rodolfo began the third day with a review of the activities of the second day. This was followed by a presentation of the group workshop results, highlighted by the projects being proposed by the participants.

    [Table 2. Proposed Projects for APEC Cooperation, based on results of Workshop on Day 2 (February 10, 2010)]

31. Atty. Anthony Amunategui Abad, EU Trade Policy Expert of the Trade Related Technical Assistance (EU TRTA) Project 2, reviewed the relevant provisions of the GATS as it applies to health services. He emphasized that there are not much movement in trade in health services commitments under the GATS.

    (Annex 25. General Agreement on Trade in Services (GATS): Health Services)

32. Ms. Joyce Socao-Alumno, Consultant of the Philippine Department of Tourism (Office for Sports & Wellness Tourism) and Secretary General of the Health & Wellness Alliance of the Philippines, then related the experience of the Philippines in terms of the advances, risks, barriers & policy challenges in medical travel. She shared global data on medical tourism, including the relative size of medical travel in selected Asian countries and information on Americans who travel for medical reasons. Among potential risks, Ms. Alumno identified equity in healthcare delivery, malpractice claims, as well as: confidentiality of data, internal brain drain, dependence on revenues derived from foreign patients, migration of healthcare workers, false claims and advertising to attract foreign patients, exploitation of poor citizens by people

who come and retire in the country, and follow-ups, complications and post-operative care. While she also mentioned organ transplantation tourism as a risk, this however was already addressed by a Philippine government regulation banning living non-related organ donation.

(Annex 26. Advances, Risks, Barriers & Policy Challenges in Medical Travel: Focus on the Philippines)

33. A synthesis of the Seminar was then presented by Mr. Ceferino Rodolfo, including (a) the issues discussed in the workshops, (b) the potential projects identified, and (c) the linkages between trade in health services and public health. Mr. Michael Lyndon Garcia of the Office of the Undersecretary for International Relations, APEC National Secretariat, Philippine Department of Foreign Affairs, was requested to give a background on the process for recommending cooperation projects in the APEC.

(Annex 27. APEC Seminar on Trade in Health Services: A Synthesis)

34. The participants then presented to the Philippine government a joint-statement on health services and trade. The participants were represented by Dr. Veerachat Petpisit, (Thailand); while the joint statement was received by Dr. Nemesio T. Gako, Assistant Secretary of the Philippine Department of Health. The joint statement emphasized the need to pursue cooperation projects *"that ensure the optimal development of international trade in health services in a manner that significantly contributes to the overall improvement of national and APEC-wide health systems, in terms of providing safe, high quality, effective, affordable, and accessible health services to all, especially to the disadvantaged segments of society."*

(Annex 28. Joint Statement on Health Services and Trade)

35. Dir. Kenneth Ronquillo presided over the Closing Ceremonies. In his Closing Remarks, Assistant Secretary Gako thanked all for their active participation and promised to take the suggested projects forward and work towards their implementation. Certificates were then awarded to the seminar participants.

(Annex 29. Closing Remarks)

APEC SEMINAR ON TRADE IN HEALTH SERVICES
Cebu, Philippines
(February 9, 10 & 11, 2010)

DIRECTORY OF PARTICIPANTS

Brunei Darussalam

1. **MS. NORAINI MANAP**
   Assistant Director for International Affairs
   Policy and Planning
   Ministry of Health
   Commonwealth Drive, Bandar Seri Begawan
   BB3910, Brunei
   Telephone No. (+673) 22380528
   Fax No. (+673) 2380128
   Email: noraini.manao@moh.gov.bn
   int_brunei@hotmail.com

2. **DR. WADI HANA SUDIN**
   Medical Officer, Internal Medicine
   Assistant to the Director of Hospital Services
   DGMS Office
   Department of Medical Services
   Ministry of Health
   Commonwealth Drive, Bandar Seri Begawan
   BB3910, Brunei
   Telephone No. (+673) 22380720
   Fax No. (+673) 2380687
   Email: wadi_hana@hotmail.com
   wadi.sudin@gmail.com

China

3. **MS. BAI XUE**
   Section Chief
   Department of Policy and Legislation
   Ministry of Health, China
   No. 1 Nanlu, Xizhimenwai
   Beijing, China
   Telephone No. (86-10) 68792302
   Fax No. (8610) 68792883
   Email: baixue@moh.gov.cn

4. **MR. GAO XINQUIANG**
   Section Chief
   Department of Medical Administration
   Ministry of Health, China

No. 1 Nanlu, Xizhimenwai
Telephone No. (86-10) 68792732
Fax No. (86 10) 68792513
Email: med2195@yahoo.com.cn

Malaysia

5. **MR. MOHD RIDHA MOHSIN**
   Special Officer to the Secretary General
   Ministry of Health, Malaysia
   Level 12, Block E7, Complex E
   Putrajaya, Malaysia
   Telephone No. 603- 8883 2546
   Fax No. 603 – 889 5245
   Email: ridha@moh.gov.my

6. **MS. NURUL ADNI ZAINUL ARIFF**
   Assistant Secretary
   Ministry of Health, Malaysia
   Block E7, Complex E, 62590
   Putrajaya, Malaysia
   Telephone No. 03-8883 2867
   Fax No. 03 8883 2331
   Email: adni@moh.gov.my
   nuruladni@gmail.com

Philippines

7. **MR. EDSEL CUSTODIO**
   Undersecretary
   Office of the Undersecretary for International Relations/
   APEC National Secretariat
   Department of Foreign Affairs
   2330 Roxas Boulevard
   Pasay City, Philippines
   Telephone No. (63 2) 834 3019
   Fax. No. 8341451

8. **MR. MICHAEL LYNDON GARCIA**
   Office of the Undersecretary for International Relations
   APEC National Secretariat
   Department of Foreign Affairs
   2330 Roxas Boulevard
   Pasay City, Philippines
   Telephone No. (+63 2) 834 3019
   Fax. No. (+63 2) 8341451
   Email: michaellyndonbgarcia@gmail.com

9. **DR. PAULYN JEAN UBIAL**
   Assistant Secretary

Field Implementation and Monitoring Office
Department of Health
San Lazaro Compound, Sta. Cruz
Manila, Philippines
Telephone No. (63 2) 7116180
Fax No. (63 2) 743-8301 loc. 1435
Email: paulyn_u@yahoo.com

10. DR. NEMESIO T. GAKO
Assistant Secretary of Health
Sectoral Management Coordinating Team
Department of Health
San Lazaro Compound, Sta. Cruz
Manila, Philippines
Telephone No. (63 2) 7438301 local 2231; 2232
Email: nemesio_gako@yahoo.com

11. DR. ELMER PUNZALAN
Assistant Secretary of Health
Office for Special Concerns
Department of Health
San Lazaro Compound, Sta. Cruz
Manila, Philippines
Telephone No. (63 2) 7438301 local 2027
Email: egpunzalan@gamial.com

12. DR. SUSANA MADARIETA
Regional Director
Center for Health Development – Central Visayas
Osmena Boulevard, Cebu City
Tel. No.: (032) 253 6355
Fax No.: (032) 254 0109
Email: skmad23@yahoo.com

13. MS. MAYLENE M. BELTRAN
Director IV
Bureau of International Health Cooperation
Department of Health
San Lazaro Compound, Sta. Cruz
Manila, Philippines
Telephone No. (63 2) 7438301 locals 1302, 1308
Fax No. (63 2) 339 38 45
Email: maylene_beltran@yahoo.com

14. DR. KENNETH G. RONQUILLO
Director IV
Health Human Resource Development Bureau
Department of Health
San Lazaro Compound, Sta. Cruz
Manila, Philippines
Telephone No. (63 2) 7431776

Fax No. (63 2) 743 1776
Email: ken2000_hhrdb@yahoo.com

15. MS. CRISPINITA VALDEZ
Director III
Information Management Service
Department of Health
San Lazaro Compound, Sta. Cruz
Manila, Philippines
Telephone No. (63 2) 7438301 locals 1926; 1927
Fax No. (63 2) 7116744
Email: cavaldz@doh.gov.ph

16. ATTY. NICOLAS LUTERO III
Director IV
Bureau of Health Facilities and Services
Department of Health
San Lazaro Compound, Sta. Cruz
Manila, Philippines
Telephone No. (63 2) 7438301 local 2505
Telefax: (63 2) 711 6982

17. ATTY. GENESIS M. ADARLO
Consultant
Department of Health
San Lazaro Compound, Sta. Cruz
Manila, Philippines
Email: gennesisadralo@gmail.com

18. DR. ANTHONY P. CALIBO
Medical Officer III
Philippine Medical Tourism Program Manager
Office for Special Concerns
Department of Health
San Lazaro Compound, Sta. Cruz
Manila, Philippines
Telephone No. 711-07-80
Email: acalibomd@yahoo.com

19. MS. LAURITA MENDOZA
Planning Officer
Health Policy Development and Planning Bureau
Department of Health
San Lazaro Compound, Sta. Cruz
Manila, Philippines
Telephone No. (63 2) 711 5377
Fax No. (63 2) 781 4362
Email: mendozalorie@yahoo.com

20. MS. JESUSA JOYCE CIRUNAY
Chief, Product Service Division

Food and Drugs Administration
Civic Drive, Filinvest Corp. City
Alabang, Muntinlupa City
Philippines
Telephone No. (63 2) 8094390
Fax. No. (63 2) 8070751
Email: jcirunay@yahoo.com

21. MS. MILLICENT JOY URGEL

Officer-in-Charge Division Chief
Public Utilities Division
National Economic Development Authority
12 St. Josemaria Escriva Drive, Ortigas Center
Pasig City, Philippines
Telephone No. (63 2) 6313739
Fax. No. (63 2) 631 3734
Email: mnurgel@neda.gov.ph

22. MS. ESPERANZA L. MELGAR

Chief Trade & Industry Development Specialist
Department of Trade & Industry, Cebu
3^{F} LDM Building, Legaspi St cor MJ Cuenco Avenue, Cebu City
Tel. No.: (63 32) 253 2631
Fax No.: (63 32) 254 0840
Email: hopemelgar@gmail.com

23. MS. MARGARET BENGZON

The Medical City
Ortigas Avenue, Pasig City
Philippines
Telephone No. (+63 2) 633 9359
Fax No. (+63 2) 633 9357
Email: mabengzon@medicalcity.com.ph
ceo@medicalCity.com.ph

24. MS. EMILY ESCASINAS

The Medical City
Ortigas Avenue, Pasig City
Philippines
Telephone No. (63 2) 633 9359
Fax No. (63 2) 633 9357
Email: epescasinas@medicalcity.com.ph
ceo@medicalcity.com.ph

25. MS. MELAHI PONS

Independent Consultant
115 Rada St., Legaspi Villalge, Makati
Tel. No.: 09391969735
Email: melahipons@yahoo.com

Singapore

26. DR. LOKE WAI CHIONG
Program Director
Health & Wellness Programme Office
Ministry of Health
College of Medicine Building
16 College Road, Singapore 169854
Mobile No. +65 90604563
Fax No. +65 62241677
Email: wai_chiong_loke@edb.gov.sg
loke_wai_chiong@moh.gov.sg

27. MS. WEI NA TAN
Senior Officer
Health and Wellness Programme Office
Singapore Economic Development Board
250 North Bridge Road # 28-00 Raffles City Tower
Singapore 179101
Mobile No. +65 98351173
Fax No. +65 68326525
Email: wei_na_tan@edb.gov.sg

Thailand

28. DR. SONGPHAN SINGKAEW
Policy and Plan Analyst, Senior Professional Level
Bureau of Policy and Strategy
Office of the Permanent Secretary
Ministry of Public Health
Tivanond Road, Nonthaburi 11000
Thailand
Telephone No. (66 2) 590 1388-9
Fax No. (66 2) 590 1380
Email: songplan@health.moph.go.th

29. DR. VEERACHAT PETPISIT
Deputy Marketing Director
Bangkok Hospital Medical Center
2 Soi Soonvijai 7, New Petchaburi Road
Bangkapi, Huay Khwang
Bangkok, 10310, Thailand
Telephone No. (66 2) 3103000 # 3198
Fax No. (66 2) 310 3105
Email: veerachat.pe@bgh.co.th
Veerachat_p@hotmail.com

Vietnam

30. MS. NGUYEN THUY PHUONG
Multilateral Economic Cooperation Department
Ministry of Foreign Affairs
No. 8 Khuc Hao
Hanoi, Vietnam
Telephone No. +84 37993211
Fax No. +84 37993618
Email: thuyphuong@mofa.gov.vn

31. DR. NGUYEN MANH CUONG
Vice-Director General
International Cooperation Department
Ministry of Health
No. 138 A Giang Vo,
Ha Noi, Vietnam
Telephone No +84 4 62732218
Fax. No. +84 4 62732239
Email: nmcntlp@yahoo.com

Main Speakers

32. MS. CATHERINA MARIA ELISABETH TIMMERMANS
Technical Officer – IPR
Trade and Health
South-East Asia Regional Office and Western Pacific Regional Office
World Health Organization
E-30 Jangpura Extension (2nd Floor)
New Delhi, India
Tel. No.: +91 11 23370804 extn. 26440
Email: TimmermansK@searo.who.int
TimmersmansC@wpro.who.int

33. MR. AMIR MAHMOOD
Assistant Professor/Deputy Head of Faculty and Assistant Dean
University of Newcastle, Australia
Faculty of Business and Law
University of Newcastle
NSW 2308 Australia
Tel. No.: (6 12) 49215017
Fax No.: (6 12) 497975
Email: Amir.Mahmood@newcastle.edu.au

34. MR. TODD NISSEN
Director
Services Trade Negotiations
Office of the US Trade Representative
600 17th Street, NW, Washington DC 20508
Tel. No.: (202) 362 9616

Fax No.: (202) 362 3891
Email: tnissen@ustr.eop.gov

35. MR. RUY MORENO

Director for Operations, Private Sector
National Competitiveness Council
6th Floor, Trade and Industry Building
361 Sen. Gil Puyat Avenue
Makati City, Philippines
Tel. No.: (+63 2) 751 0384 local 2626
Fax No.: (+63 2) 751 3404
Email: ncc.dti@gmail.com

36. MS. KATHLEEN FRITSCH

Regional Adviser in Nursing
WHO Office for the Western Pacific
P.O. Box 2932, U.N. Avenue,
1000 Manila, Philippines
Tel. No.: (+63 2) 528 9804
Fax No.: (+63 2) 521 1036
Email: fritschk@wpro.who.int

Guest speakers from the Philippines:

37. DR. SHIRLEY DOMINGO

Philippine Health Insurance Corporation
City State Center, 709 Shaw Blvd.
Pasig City, Philippines
Telefax No.: (+63 2) 706 4049
Email: sbdomingo@philhealth.gov.ph

38. MR. THEO SEILER

Chief Executive Officer
Asian Hospital and Medical Center
2205 Civic Drive, Filinvest Corporate City
Alabang, Muntinlupa City
Tel. No.: (+63 2) 876 5711
Fax No.:(+63 2) 876 5710
Email: tseiler@asianhospital.com

39. MS. CYNTHIA LAZO

Director of Wellness and Health
Department of Tourism
T.M.Kalaw, Manila
Tel. No.:
Fax No.:
Email: mmadb@yahoo.com

40. PROF. FELY MARILYN LORENZO
(Contact Details in List of Convenors)

41. ATTY. ANTHONY AMUNATEGUI ABAD
Trade Policy Expert
Trade-Related Technical Assistance Project 2
Trade and Industry Building
361 Sen. Gil Puyat Avenue, Makati City
Tel. No.: (+63 2) 395 7328
Fax No.: (+63 2) 891 1889
Email: aaaabad@tatrade.net

42. MS. JOYCE ALUMNO
Consultant
Department of Tourism
T.M. Kalaw Avenue, Manila
Tel. No.: (+63 2) 468 9999
Fax No.: (+63 2) 637 2673
Email: jsalumno@gmail.com

Secretariat

43. MS. GEORGINA E. RAMIRO
Officer-in-Charge, International Relations Division
Chief Health Program Officer
Bureau of International Health Cooperation
Department of Health
Tel. No.: (+63 2) 743 8301 loc. 1338
Fax No.: (+63 2) 781 8843
Email: ger_nd@yahoo.com

44. DR. ALLAN EVANGELISTA
Chief Health Program Officer
Bureau of International Health Cooperation
Department of Health
Tel. No.: (+63 2) 743 8301 loc. 1338
Fax No.: (+63 2) 781 8843
Email: aemd.angel@gmail.com

45. MS. SOCORRO BALBINO
Supervising Health Program Officer
Bureau of International Health Cooperation
Department of Health
Tel. No.: (+63 2) 743 8301 loc. 1338
Fax No.: (+63 2) 781 8843
Email: lance_nonie@yahoo.com

46. MS. HEIDI UMADAC
Senior Health Program Officer

Bureau of International Health Cooperation
Department of Health
Tel. No.: (+63 2) 743 8301 loc. 1338
Fax No.: (+63 2) 781 8843
Email: hi_dcu2002@yahoo.com

47. MS. MARIA CRISTY N. YUSON

Senior Health Program Officer
Bureau of International Health Cooperation
Department of Health
Tel. No.: (+63 2) 743 8301 loc. 1338
Fax No.: (+63 2) 781 8843
Email: mariacristy_yuson@yahoo.com

Convenors

MS. FELY MARILYN LORENZO

Professor
College of Public Health
University of the Philippines and
Acting Director
Institute of Health Policy and Development Studies
National Institute of Health
Telefax: (+63 2) 450 80 90
Email: marilynlorenzo@gmail.com

48. MR. CEFERINO RODOLFO

Program Director
Master of Science in Management
University of Asia and the Pacific
Tel. No.: (+63 2) 637 0912 to 25 local 243
Fax No.: (+63 2) 634 2823
Email: psrodolfo@uap.edu.ph

49. MS. MA. CHERRYLYN RODOLFO

Senior Economist
University of Asia and the Pacific
Tel. No.: (+63 2) 637 0912 to 25 local 243
Fax No.: (+63 2) 634 2823
Email: cherrylyn.rodolfo@gmail.com

APEC Seminar on Trade in Health Services
9-11 February 2010
Cebu, Philippines

PROGRAM AGENDA

DATE and TIME	ACTIVITY	SPEAKERS
February 9, 2010		
AM Sessions		
8:30 – 9:00	Registration	
9:00 – 9:30	Opening Ceremonies	
9:30 – 10:00	***Presentation 1*** Brief Overview of GATS and Trade in Health Services	**Ms. Catherina Timmermans** *Regional Focal Point for Trade and Health* *World Health Organization*
10:00 – 10:15	Coffee Break	
10:15 – 10:45	***Presentation 2*** Trade in Services in the Diagnostic Tool on Trade and Health: Relevance, Updates and Experiences in Implementation	**Ms. Catherina Timmermans**
10:45 – 11:15	***Presentation 3*** Lecture in Linkages Across Modes and Across Sectors (Complimentary Linkages, Substitute Linkages and Negative Linkages)	**Prof. Amir Mahmood** *Associate Professor/* *Deputy Head of Faculty &* *Assistant Dean* *International Faculty of Business & Law* *The University of Newcastle* *Australia*
11:15 – 11:45	Q & A	
11:35	Lunch Break	
PM Sessions		
1:00 -1:30	***Discussion 1*** Advances, Risks, Barriers and Policy Challenges in Tele-Health	**Prof. Amir Mahmood**
1:30 – 1:45	***Discussion 2*** Experience on Clinical Research Development	**Dr. Loke Wai Chiong** *Health & Wellness Program Office,* *Ministry of Health* *Singapore*
1:45 – 2:00	***Discussion 3*** Medical Tourism, Health and Wellness	**Mr. Ruy Y. Moreno** *Director for Operations in the Private Sector* *National Competitiveness Council, Philippines*
2:00 – 2:30	Q & A	
2:30 – 3:00	***Workshop 1:*** Barriers and Opportunities on Trade in Health Services	

DATE and TIME	ACTIVITY	SPEAKERS
February 9, 2010 *…continued*		
PM Sessions		
3:00 – 3:15	Coffee Break	
3:15 – 4:00	Continuation of Workshop	
February 10, 2010		
AM Sessions		
8:00 – 8:15	Recap of Day 1	
8:15 – 8:45	Presentation of Outputs of Workshop 1	
8:45 – 9:15	**Borderless Medical Travel in APEC** ***Presentation 4*** Insurance Portability and Trade Facilitation: Benefits, Barriers, Solutions and Agenda for APEC Cooperation (Experience of Developed Economies as Sending Countries)	**Mr. Todd Nissen** *Director for Services Trade Negotiations* *Office of the United States Trade Representative* *Washington DC, USA*
9:15 – 9:30	***Discussion 4*** Insurance Portability and Trade Facilitation: Benefits, Barriers, Solutions and Agenda for APEC Cooperation (Experience of Developing Economies as Receiving Countries)	**Dr. Veerachat Petpisit** *Deputy Marketing Director* *Bangkok Hospital Medical Center* *Thailand*
9:30 – 9:45	***Discussion 5*** Measuring Quality of Healthcare through Accreditation of Health Service Providers and Facilities	**Dr. Shirley B. Domingo** *Senior Vice-President for Health Financing Policy* *Philippine Health Insurance Corporation, Philippines*
9:45 – 10:00	***Discussion 6*** Impact of Trade in Health Services on Public Health and Policy Responses	**Dr. Songphan Singkaew** *Policy & Plan Analyst* *Bureau of Policy & Strategy Office of the Permanent Secretary* *Ministry of Public Health* *Thailand*
10:00 – 10:15	Q & A	
10:15 – 10:30	Coffee Break	
10:30 – 10:45	**Developments in Investment Climate** ***Discussion 7*** Experiences in Establishing Overseas Presence	**Dr. Veerachat Petpisit**
10:45 – 11:00	***Discussion 8*** Impact of Foreign Investments on Public Health	**Mr. Theo Seiler** *Chief Executive Officer* *Asian Hospital, Philippines*
11:00 – 11:15	***Discussion 9*** Experiences on Registration of Medical Tourism Economic Zones	**Atty. Genesis Adarlo** *Consultant for DOH & WHO Philippines*

DATE and TIME	ACTIVITY	SPEAKERS
February 10, 2010 *…continued*		
AM Sessions		
11:15 – 11:30	***Discussion 10*** Trade in Health Services Statistics	**Ms. Cynthia Lazo** Director of Wellness and Health Department of Tourism, Philippines
11:30 - 11:45	Q & A	
11:45	Lunch Break	
PM Sessions		
12:45 – 1:15	**Liberalization of Professional Practice: Recent Developments, Modalities and Impacts** ***Presentation 5*** Development of Mutual Recognition Agreements (MRAs) and Common Competency Standards	**Ms. Kathlyn Fritsch** *Regional Adviser in Nursing* *WHO Regional Office for Western Pacific (WPRO)* *P.O. Box 2932, UN Avenue* *1000 Manila, Philippines*
1:15 – 1:30	***Discussion 11*** Philippine Experience on MRAs	**Dr.Kenneth G. Ronquillo** *Director IV* *Health Human Resource Development Bureau* *Department of Health* *Philippines*
1:30 – 1:45	***Discussion 12*** Cooperation Agreements to Address Equity Issues	**Prof. Fely Marilyn E. Lorenzo** *Professor* *College of Public Health* *University of the PhilippinesManila*
1:45 – 2:00	Q & A	
2:00 – 3:00	***Workshop 2:*** Identifying and Prioritizing Cooperation Projects on Trade in Health Services	
3:00	**Health Facilities Visit:** Vicente Sotto Memorial Medical Center Chong Hua Hospital	

DATE and TIME	ACTIVITY	SPEAKERS
February 11, 2010		
AM Sessions		
8:00 – 8:15	Recap of Day 2	
8:15 – 8:45	Presentation of Outputs of Workshop 2	
8:45 – 9:15	***Presentation 6*** GATS and Trade in Health Services: The Progress So Far, Experiences at the Bilateral, Regional and Multilateral Level	**Atty. Anthony Amunategui Abad** *Trade Policy Expert* *Trade Related Technical Assistance Project (TRTA)-2* *Philippines*
9:15 – 9:30	***Discussion 13:*** Advances, Risks, Barriers and Policy Challenges in Medical Travel	**Ms. Joyce Alumno** *Consultant* *Department of Tourism, Philippines*
9:30 – 9:45	Q & A	
9: 45 – 10:15	Presentation of Synthesis	
10:15 – 10:30	Coffee Break	
10:30 – 11:30	Endorsement of Proposals for Areas of Cooperation	
11:30 – 12:00 NN	Closing Ceremonies	
END OF PROGRAM		

Welcome Remarks

By:

HON. EDSEL T. CUSTODIO
Undersecretary for International Economic Relations and
Philippine Senior APEC Official
Department of Foreign Affairs

Good morning. I am very honored for this opportunity to welcome all participants to this APEC Seminar on Trade in Health Services.

I would like to acknowledge and congratulate the hard-working staff of the Bureau of International Health Cooperation of the Department of Health for making this project possible.

I would like to particularly welcome our participants from our APEC partner economies including Indonesia, Thailand, and Singapore who are co-sponsors of this project.

Let me also express my appreciation for the hospitality being extended by the people and government of the City of Mactan to welcome our guests from the APEC community.

In this three-day seminar, we will be discussing the various factors that facilitate or hinder the free flow of trade in health services.

Trade in services, in general, is considered as the new frontier of international trade. The global services sector has been a credible engine of growth and has demonstrated resiliency even during the onslaught of the global economic crisis that began in late 2008. Measurement of trade in services remains a challenge owing to the non-tangible nature of services. Health services trade is no exception but the rising number of medical tourists and the increasing demand for health professionals are clear indications of the strong growth potential of health services trade.

Health services trade cuts across all modes of supply under the GATS classification. Health-related services under Mode 1 is limited due to the nature of the service provided mainly through electronic means. Mode 3 or commercial presence remains limited in many economies in the region due to limitations in foreign equity. Much of the trade in health services focus on Modes 2 and 4 since health services require close contact between the consumer and the health service provider such as in medical

tourism, commercial presence of health service providers, or cross-border movement of health professionals.

Medical tourism is a high-repeat user business with the potential to attract high-income consumers. It works in tandem with the tourism industry through information provided to tourists on available medical amenities in popular tourist destinations. Medical tourism has the added benefit of encouraging health professionals to stay in the home country. The success of medical tourism depends on the existence of a comprehensive policy and regulatory framework that will adequately address the issues of insurance portability, regulation of foreign health professionals, consumer protection, and health data privacy.

Trade in health services under Mode 4 is a promising source growth for developing economies. It is similarly important to developed economies which are experiencing demographic changes resulting in increasing demand for health workers to provide care for the aging population. This mutually beneficial arrangement, however, has engendered new problems. Sending economies have to develop measures in order to cope with the negative consequences of labor migration in meeting domestic health requirements. Foreign workers are sometimes victim to exploitative recruitment and processing fees, unsuitable working conditions, and inferior compensation packages. Addressing such problems would require the cooperation of receiving economies to protect foreign workers and prevent unfair and abusive practices. Canada, for instance, has effectively addressed such concerns through the Temporary Foreign Worker Program. Mutual recognition arrangements, however, is widely acknowledged as the best approach to maintain the quality of health education and protect the welfare of health professionals abroad.

I have only given you a snapshot of the range of issues that this seminar will address. The programme prepared for this seminar was designed to cover as comprehensively as possible all the relevant aspects of health services trade. I hope you will find the discussions very useful.

At this point, allow me to thank in advance all our invited resource speakers for sharing their valuable time and expertise with us. I encourage all participants to actively participate in the seminar. I hope that with better of understanding of the issues, we would be guided in mapping out directions for our future work in this area. I am optimistic that APEC economies would continue to actively collaborate through the APEC Group on Services and the Health Working Group.

Again, welcome to all our participants. I wish you will all have an enjoyable stay in Cebu.

Mabuhay!

Delivered during the Opening Ceremonies of the Seminar on Trade in Health Services, 9-11 February 2010, Shangri-la Mactan, Cebu, Philippines

Welcome Remarks

By:

Dr. PAULYN JEAN ROSELL-UBIAL
Assistant Secretary
Field Implementation Management Office
Department of Health

COLLEAGUES AND FRIENDS, DISTINGUISHED GUESTS, LADIES AND GENTLEMEN,

In behalf of our President, Her Excellency Gloria Macapagal Arroyo and our Health Secretary, Dr. Esperanza Cabral, with my co-members of the EXECOM, Assistant Secretary Nemesio T. Gako, Assistant Secretary Elmer Punzalan, BIHC headed by Director Maylene Beltran, Center for Health Development – Central Visayas, headed by Director Susana Madarieta and the entire Department of Health family especially CHD-7, the Philippines is very pleased to be the host of this Seminar and I warmly welcome all of you to this APEC Seminar on Trade in Health Services. I would also like to offer a special welcome to the delegates of APEC member economies who are participating in this Seminar. The success of the Seminar largely hinges on your active participation to the discussions and your commitment to the future action points that will be agreed later on.

I will not go through the main features of the Seminar in any detail, as you are about to hear them from some of the resource speakers and member economy representatives.

While our schedules within the next two and a half (2 ½) days will be full, we will strive to make each and every one of you feel the hospitality and friendliness which our people are known for. Together with the valuable inputs of the Seminar, we will aim to make you bring home memories of the beauty of this country and the richness of its culture and heritage.

MABUHAY! This is our greetings to welcome guests here in the Philippines. It means “be alive”, be happy, have fun, enjoy life, be alive.

Learning is more efficient – we absorb more if we enjoy and have fun in the processes. We come to better decisions and discussions in an atmosphere of congenial and “happy” disposition.

In conclusion, I would like to thank you and to ask all of you to help ensure the utmost benefit from this Seminar through sound discussions, open exchange of ideas, and positive commitment to enhancing future actions on trade in health services in the APEC region towards better health outcomes for all our people in this Region.

I wish you all a successful meeting and a pleasant stay in Cebu. Mabuhay!

Delivered during the Opening Ceremonies of the Seminar on Trade in Health Services, 9-11 February 2010, Shangri-la Mactan, Cebu, Philippines

APEC Seminar on Trade in Health Services: An Overview

Dir. Maylene M. Beltran
Director IV
Bureau of International Health Cooperation
Department of Health

Cebu City, Philippines
9-11 February 2010

1

Seminar Context

- Increasing international tradability of health, across different modes of supply (e.g. medical transcription, medical travel, investments, and migration), driven by developments in ICT, rapidly ageing population, robust economic opportunities, and others.
- There is a need to define trade in health services--the opportunities, challenges, and risks--in the context of public health realities.
- Different experiences among APEC economies in the field of trade in health services
  - Opportunities to learn from each other through sharing of experiences
  - Identify and explore possible cooperation projects

2

Seminar Objectives

1. To exchange information on the more recent developments and issues in health services trade among APEC member economies and promote a common understanding of these issues
2. To exchange experiences on policies, practices and processes in addressing the various issues and in coping with the impacts related to health services trade and liberalization
3. To identify the tasks for immediate and future cooperation among APEC member economies.

3

Seminar Methodologies

- **Five (5) Presentations**, elaborating on general issues on trade in health services
- **Thirteen (13) Discussions**, focusing on specific country experiences
- **Q&A Sessions**, to clarify or highlight points made by the speakers, to expound by citing additional country experiences, or to offer alternative perspectives
- **Two (2) Workshops**, to build a common understanding of the lessons from the presentations and country experiences; and to identify and explore areas for cooperation
- **Two (2) Site Visits**—to a modern private hospital and to a government-run hospital—in order to contextualize discussions to the realities of a national health system and to illustrate the opportunities, challenges and risks accompanying trade in health services.

4

Presentations

1. Brief Overview of GATS and Trade in Health Services
2. Diagnostic Tool on Trade and Health: Relevance, Updates and Experiences in Implementation
3. Lecture in Linkages Across Modes and Across Sectors (Complimentary Linkages, Substitute Linkages and Negative Linkages)
4. Insurance Portability and Trade Facilitation: Benefits, Barriers, Solutions and Agenda for APEC Cooperation (Experience of Developed Economies as Sending Countries)
5. Development of Mutual Recognition Agreements (MRAs) and Common Competency Standards.
6. GATS and Trade in Health Services: The Progress so Far, Experiences at the Bilateral, Regional and Multilateral Level

5

Discussions (1/3)

Topic	Country
Advances, Risks, Barriers and Policy Challenges in Tele-Health	Australia
Experience on Clinical Research Development	Singapore
Medical Tourism, Health and Wellness	Philippines
Insurance Portability and Trade Facilitation: Benefits, Barriers, Solutions and Agenda for APEC Cooperation (Experience of Developing Economies as Receiving Countries)	United States
Measuring Quality of Healthcare through Accreditation of Health Service Providers and Facilities	Philippines

6

Discussions (2/3)

Topic	Country
Impact of Trade in Health Services on Public Health and Policy Responses	Thailand
Experiences in Establishing Overseas Presence	Thailand
Impact of Foreign Investments on Public Health	Philippines
Experiences on Registration of Medical Tourism Economic Zones	Philippines
Trade in Health Services Statistics	Philippines
Philippine Experience on MRAs	Philippines

7

Discussions (3/3)

Topic	Country
Cooperation Agreements to Address Equity Issues	Philippines
Advances, Risks, Barriers and Policy Challenges in Medical Travel	Philippines

8

Workshops

1. Barriers, Opportunities and Risks on Trade in Health Services—Linkages with Health Systems.
2. Identifying and Prioritizing Cooperation Projects on Trade in Health Services.

9

Site Visits

- Vicente Sotto Memorial Medical Center
- Chong Hua Hospital

10

GATS & trade in health services: a brief overview

Karin Timmermans
WHO SEARO & WPRO

APEC Seminar on Trade in Health Services
Cebu, Philippines 9-11 February 2010

1

- Trade in Health Services
- GATS
- A way forward…?

2

GATS distinguishes 4 ways, or 'modes', of providing services:

1. Cross-border supply:	international phone calls, 'telemedicine'
2. Consumption abroad:	tourism, patients seeking treatment abroad
3. Commercial presence:	subsidiaries of foreign firms, foreign-owned hospitals
4. Movement of natural persons:	foreign workers, incl. doctors, nurses

3

Mode 1: cross-border supply

telemedicine

Negative:

- Can divert funds away from basic health services;
- May cater only for urban upper and middle classes;
- Could divert human resources away from remote areas or basic services (internal 'brain drain')

Positive:

- Could help to extend sophisticated services to remote areas;
- Facilitate dissemination of knowledge and upgrade skills;
- May alleviate human resource constraints

4

Mode 2: consumption abroad

Treatment abroad

Negative:

- Can divert funds away from services for nationals;
- 'Crowding out' of locals;
- Two-tier system
- Only for the rich?

Positive:

- Increase quality of services;
- revenues could be used to upgrade/expand domestic services;
- May alleviate capacity constraints;
- Reduce costs/make additional services available

5

Mode 3: commercial presence

Foreign-owned hospital/insurance

Negative:

- Risk of 'cream-skimming';
- Could increase the internal 'brain drain';
- There may be hidden costs associated with efforts to attract foreign direct investment

Positive:

- Could improve quality and standards;
- May facilitate technology transfer;
- Creates employment opportunities

6

Mode 4: movement of natural persons

Migration of health personnel

Negative:

- May create shortages at home;
- Migrating professionals are often relatively highly qualified;
- The poorer country ends up subsidizing the health system of the more affluent country

Positive:

- Upon their return, professionals may have additional knowledge and skills that could benefit the domestic health care system;
- for some small countries, migration may be the most efficient way to build HRH

7

Trade in Health Services

GATS

A way forward…?

8

the General Agreement on Trade in Services = GATS =

- First multilateral, enforceable agreement on trade in services;
- Objectives: non-discrimination, increased transparency and progressive liberalization of trade in services;

Non-discrimination:

- **Most-favored nation (MFN) treatment**: all trading partners are to be treated the same;
- **National treatment**: foreign companies and national companies are to be treated the same.

9

GATS is a framework agreement;

its actual content -and the implications at national level- depends largely on the individual country's commitments

=> GATS is quite flexible

=> GATS is complex

10

During GATS negotiations, countries make commitments to open up certain sectors or sub-sectors, i.e. they make market access commitments.

Unless explicitly indicated otherwise, commitments are 'bound': modification or withdrawal can result in requests for compensations from affected countries.

=> Commitments virtually guarantee a minimum level of market access

The commitments are written in "schedules".

11

Schedules:

- 'horizontal part' – applicable to all sectors
- 'vertical' part – sector specific
- limitations on market access
- exceptions to national treatment

If a limitation or exception has not been entered in the schedule of a committed sector, it cannot be used.

=> Making GATS commitments may limit policy options

12

Example of a schedule - hospital services, India:

Sector or sub-sector	Limitations on market access	Limitations on national treatment	Additional comments
Hospital services (CPC 9311)	1. Unbound * 2. Unbound 3. Only through incorporation with a foreign equity ceiling of 51 percent 4. Unbound except as indicated in the horizontal section	1. Unbound 2. Unbound 3. None 4. Unbound except as indicated in the horizontal section	

13

GATS is a framework agreement;

its actual content -and the implications at national level- depends largely on the individual country's commitments

=> GATS is quite flexible

=> GATS is complex

… and GATS is 'a work in progress' …

14

Work in progress:

GATS does allow ***non-discriminatory*** domestic regulations, such as licensing and qualification requirements, regulations on technical standards etc.

=> Governments are free to develop regulations to guarantee the quality of health services.

Rules are being developed to ensure that 'domestic regulations' are based on objective & transparent criteria, and are not more burdensome than necessary.

15

Uncertainties in GATS:

- General exception for health – "nothing in this agreement shall be construed to prevent the adoption or enforcement … of measures … necessary to protect human, animal or plant life or health"

  when will a measure be considered necessary?

- GATS does not apply to 'governmental services' – i.e. services "supplied neither on a commercial basis nor in competition with one or more service suppliers"

  do fees render public health services 'commercial'?

16

Trade in Health Services

GATS

A way forward…?

17

Trade

Increase trade

Liberalize trade

Increase transparency

Enhance economic development

18

Trade	Health
Increase trade	Ensure quality
Liberalize trade	Increase equity
Increase transparency	Ensure efficiency
Enhance economic development	**Equitable access to good services**

?

19

Starting point:

Thorough analysis to

- Review the current national situation with regard to trade in health services;
- Identify opportunities and risks;
- Devise strategies to make use of the opportunities and to mitigate the risks, within the GATS framework of rules.

20

Potential problems:

- Lack of data
- Focusing on the wrong questions
- There is limited time
- MOH not familiar with the topic
- Uncertainties in GATS

21

Options for countries:

- Do not commit to liberalizing trade in health services;
- If and where trade liberalization is considered advantageous, opt for ***unilateral*** liberalization first, in order to gain experience and evidence, before making binding commitments;
- Consider making demands to other countries in those modes where you have a comparative advantage

22

Scope of GATS

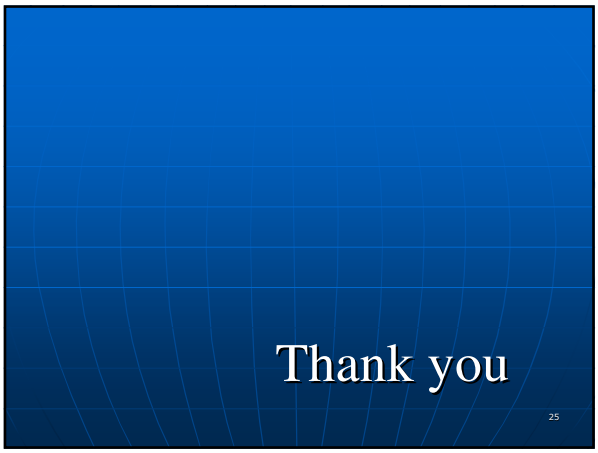
	incoming	outgoing
1. Cross-border supply:	…	…
2. Consumption abroad:	…	…
3. Commercial presence:	…	…
4. Movement of natural persons:	…	…

23

Scope of GATS

	incoming	outgoing
1. Cross-border supply:	v	v
2. Consumption abroad:		v
3. Commercial presence:	v	
4. Movement of natural persons:	v	

24


Thank you
25

A diagnostic tool on trade and health: background, update and experiences

Karin Timmermans
WHO SEARO & WPRO

APEC Seminar on Trade in Health Services
Cebu, Philippines 9-11 February 2010

1

- International trade and trade agreements increasingly affect health;

2

WTO Agreements relevant for public health (examples)

WTO RULES	SPS	TBT	TRIPS	GATS
HEALTH ISSUES				
• Infectious disease control	*	*		
• Food safety	*			
• Tobacco control		*	*	*
• Environment	*	*		
• Access to medicines			*	
• Health services				*
• Food security	*			
EMERGING ISSUES				
• Biotechnology	*	*	*	
• Information Technology			*	
• Traditional knowledge			*	

3

- International trade and trade agreements increasingly affect health;
- Yet health professionals and policymakers are, traditionally, not familiar with trade rules.

4

Trade	**Health**
Increase trade	Ensure quality
Liberalize trade	Increase equity
Increase transparency	Ensure efficiency
Enhance economic development	**Equitable access to good services**

5

Resolution WHA59.26:
International Trade and Health

Calls on WHO Member States to ensure that health and trade are balanced, and

- to promote intersectoral dialogue and establish coordination mechanisms;
- to adopt policies, laws and regulations to harness the opportunities and address the challenges;
- to generate coherence in trade/health policies;
- to develop capacity to track and analyse the impact of trade and trade agreements on health.

6

- To underpin these:
  need a comprehensive national assessment of issues at the interface of trade and health
- This requires:
  - Knowledge about international trade agreements and how they operate
  - An analytical framework to systematically analyze the health implications of trade

7

- To underpin these:
  need a comprehensive national assessment of issues at the interface of trade and health
- This requires:
  - Knowledge about international trade agreements and how they operate
  - An analytical framework to systematically analyze the health implications of trade

The development of a “diagnostic toolkit” for trade and health was initiated by WHO HQ

8

Diagnostic toolkit on trade & health - objectives

- Facilitate a comprehensive national analysis of trade and health, as a basis for:
  - conducting intersectoral dialogues
  - increasing policy coherence
  - devising policy measure to capture the opportunities and mitigate potential risks

Diagnostic toolkit on trade & health - objectives

- Facilitate a comprehensive national analysis of trade and health, as a basis for:
  - conducting intersectoral dialogues
  - increasing policy coherence
  - devising policy measure to capture the opportunities and mitigate potential risks
- Input into trade negotiations
- Identification of knowledge or capacity gaps, and thus of capacity building needs

10

Diagnostic toolkit – elements

General:
- Population health and national health system
- Macro-economic and trade environment

Specific:
- Trade in harmful and hazardous products
- Trade in foodstuff
- Trade in health goods (medicines, diagnostics, medical equipment etc.)
- Trade in health services (all 4 modes)

11

Diagnostic toolkit – sub-elements

- performance, characteristics, approaches and priorities
- what is being traded: exports/imports
- offensive/defensive interests
- applicable trade rules and agreements and issues related to ongoing negotiations
- health implications
- trade implications
- existing regulatory environment
- flanking policies under consideration
- mechanisms for policy coherence
- capacity gaps/needs

12

	-health status & system -macro-economic & trade	hazardous products	foodstuff	health goods	health services
Performance, characte-ristics, approach, priorities					
What is being traded (imports and exports)					
Offensive/defensive interests					
Ongoing negotiating issues related to trade rules and agreements					
Health implications					
Regulatory issues & Flanking policies					
Mechanisms/capacity for policy coherence					
Capacity building needs					

13

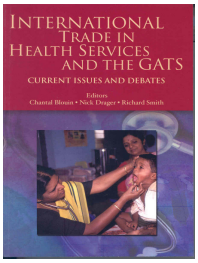
Diagnostic toolkit – structure

- A questionnaire with 4 main sections: hazardous goods, health goods, health services, foodstuffs
- A 'workbook' to facilitate the use of the questionnaire:
  - Suggestions for data sources
  - International norms and standards
  - Case studies, examples and good practices
  - References to existing methodologies
  - Links to relevant information and resources
  - But not 'prescriptions'

14

Diagnostic toolkit – development process

- Modeled on the earlier framework for analysis of trade in health services;
- Consultations to obtain input;
- Experts to draft;
- Peer reviews of drafts;
- Field tests.



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"field tests"

- Experiences with the framework for analyzing trade in health services:
  - research project in the Eastern Mediterranean Region: 10 countries, using an adapted and simplified version of the framework
  - several individual country studies in Asia
- Field tests of parts of the diagnostic toolkit
  - so far, only a few countries, still ongoing
  - only selected parts: i) trade in health services, or ii) trade in foodstuff, or both

16

Strengths of the (health services) framework

- Provides a systematic approach to collecting data on most aspects of trade in health services
- Proposed methodology permits comparison across countries, especially those at a similar level of socioeconomic development
- Data collection can result in increased (informal) intersectoral dialogue
- Provides a basis for improved policy coherence on key issues among trade and health sector

17

Challenges

- It is not always possible to accurately estimate the direction, volume and value for all modes of trade in health services
  - Measuring the volume of trade (e.g. no. of patients going abroad, no. of health personnel moving to another country)
  - Estimation of the monetary value
- In the absence of information systems/surveys on trade in health services, innovative and novel approaches are required
- Limited institutional capacity for undertaking independent work on trade in health services

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Lessons

- Learn trade jargon and trade-and-health issues beforehand
- Use of the tool/framework is not self-explanatory; it requires further guidance
- Intersectoral teams of public health and trade professionals do better than either alone
- Collecting the information and analyzing it are two distinct steps; the analysis does not automatically roll out of the data
- The framework is not designed to assess the ***impact*** of liberalizing international trade in health services on the health system

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Annex 7. Trade in Health Services_Linkages across modes and sectors

Trade in Health Services: Linkages Across Modes and Sectors

Dr. Amir Mahmood
Associate Professor in Economics and International Business
Faculty of Business & Law
University of Newcastle, Australia

1

Trade in Health Services: Inter-modal and Inter-sectoral Linkages: Key Questions

- What drives health services trade?
- How to maximise positive linkages and minimize the negative linkages across modes to maximise return for all stakeholders?
- How to identify and facilitate the key mode of supply that is a source of positive externalities?
- How to identify the key channels or processes that result in inter-modal dynamics and positive externalities?
- What governments can do to nurture positive linkages across modes and across sectors?
- Why healthcare providers choose particular modes to export a service?

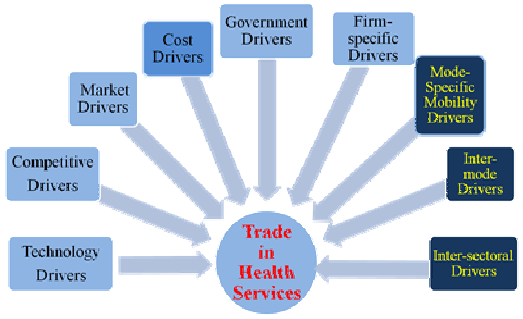
2

Services Trade and GATS Delivery Mode

Trade Mode	Mobility	Delivery
Mode 1	Healthcare Service Mobility	ICT (Providers from the Philippines delivering transcription services to the US hospitals)
Mode 2	Patient Mobility	In-country provision of healthcare services to foreign patients (Hospitals in Singapore treating patients from Indonesia)
Mode 3	Institution Mobility	Stetting up of offshore subsidiaries/ branches to provide services to local patients (Apollo Hospital in Sri Lanka)
Mode 4	Healthcare Professional Mobility	Offshore provision of services by professionals (Fly-in-fly-out medical services provided by the Indian doctors in Gulf/Sri Lanka)

3

What Drives Trade in Health Services?



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Factors Driving Trade in Health Services

Market Drivers

- Ease of travel across borders
- Nature of healthcare markets(extent of commercialisation)
- Globalisation of markets and convergence of life style
- Rising income
- Ageing/fast growing populations
- Emergence of a middle class in developing countries
- Growth of regional & global channels to deliver healthcare services (Apollo Hospitals)
- Emerging global brands
- Saturation of markets in home country

Cost Drivers

- Demand/supply (availability) conditions of health care services & professionals across countries
- Increased healthcare cost pressures
- Globalisation of production through outsourcing, global sourcing, and off shoring
- Country-specific cost advantages/disadvantages
- Economies of scale & scope in the provision of healthcare services

5

Factors Driving Trade in Health Services

Government Drivers

- Decline in public sector expenditure
- GATS as driver of trade in services
- Deregulation in insurance and telecommunications sectors
- Liberalization of investment regulations
- Removal of regulatory barriers to health services trade at the regional, multilateral, and the national levels

Competitive Drivers

- Increased information
- Relative comparative advantages in production & delivery of healthcare services across countries
- Growing private healthcare enterprises
- Product differentiation in healthcare services
- Mergers and acquisitions
- Difference in quality of healthcare across countries
- Emergence of investment opportunities in the health care sector

6

Annex 7. Trade in Health Services_Linkages across modes and sectors

Factors Driving Trade in Health Services

Technology Drivers

- Technological advancements & efficient communication systems
- New medical developments
- Technology-driven productivity gains in health sector

Other Drivers

- Inter-Modal Drivers
- Inter-Sectoral Drivers
- Mode-specific Mobility Drivers
- Firm-specific Drivers

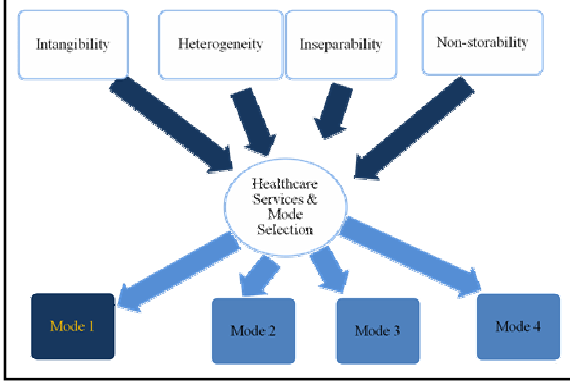
7

Trade in Health service: Firm-specific Drivers

- Firm-specific resources, skills, knowledge, and competencies
- Global/regional mindset
- Market sector selection and resource deployment
- Designated resources to assist export activity
- Local/national/regional/international professional networking
- Export friendly IT platform
- Lobbying with host governments and organisations
- Strategic alliances and partnerships (e.g. Australian partnerships with the Chinese hospitals)

8

Healthcare Services Characterises & Mode of Supply



Healthcare Services Characterises & Mode of Supply

Intangibility, Non-storability & Inseparability of healthcare services → Physical proximity of Healthcare service providers and patients ➔ Modes 2, 3,& 4

10

Healthcare Services Characterises & Mode of Supply

Advancements in ICT →

- Physical proximity is no-longer a distinctive feature for a range of healthcare services ➔separability
- Physical proximity has been replaced by on-line proximity ➔ Mode 1

11

Healthcare Services Trade and Delivery Modes: Key Observations

- Intangibility and inseparability are not the only factors determining the choice of healthcare service delivery mode
- A healthcare provider's resources, capabilities, and strategic orientation play dominant role in delivery mode selection
- Every mode of delivery is subject to perceived risks, costs, constraints, and benefits, which may vary across service delivery modes
- One provider may use all four modes to export healthcare services

12

Annex 7. Trade in Health Services_Linkages across modes and sectors

Exploiting Cross-sector and Inter-mode Interdependencies: Apollo Group of Hospitals

- Apollo International Patient Services (health tourism)➔ Mode 2
- Apollo Telemedicine (e-health education, back office operations) ➔ Mode 1
- Apollo Global Project Consultancy ➔ Mode 1, 2, 3, 4
- Apollo Munich Insurance ➔ Mode 3

13

Cross border- Service Mobility Drivers: Mode 1

Key Mode-Specific Mobility Drivers

- Increases separability of services from their production processes
- Advancement in ICT
- Declining costs of electronic delivery
- High connectivity

→ Tele-health (telemedicine, medical education, health management and health data system, data storage & usage)

14

Customer Mobility Drivers: Mode 2

Key Mobility Drivers

- Geographical and cultural proximity
- Relative price and quality of healthcare
- Ease of cross border movement of patients
- Portability of health insurance
- presence of supporting services and amenities
- country and industry branding
- economic, social, cultural, legal, and security environment
- Consumer preferences
- Existence of alternative medicine and treatment

→ Medical Travel

15

Institution Mobility Drivers: Mode 3

Key Mobility Drivers

- Firm-specific Advantages
- Internationalisation Motives
- Location-specific advantages (including access to health professionals and paramedics)
- Degree of privatisation & Commercialisation

→ Commercial Presence

- Establishment of healthcare/health education entities and enterprises
- Mergers and acquisitions

16

Professionals' Mobility Drivers: Mode 4

Key Mobility Drivers

- Prevailing skill-gaps
- Different resource and demand conditions (concentration of well-trained, low-cost, medical and healthcare professionals)
- Wage differentials
- Different levels of economic development
- Regulatory and entry requirements in host countries
- Similarity of demand
- Level of economic integration
- Geographical and cultural proximity

→ Across Border Temporary Movement of:

- Doctors
- Nurses
- Paramedics
- Midwives
- Technicians
- Consultants
- Health Management Personal

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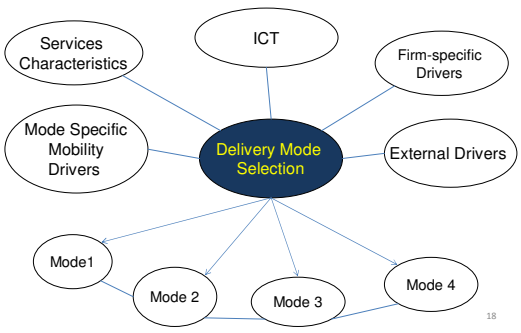
Export of Health Service: Dynamics of Delivery Mode Selection & Inter-modal Linkages



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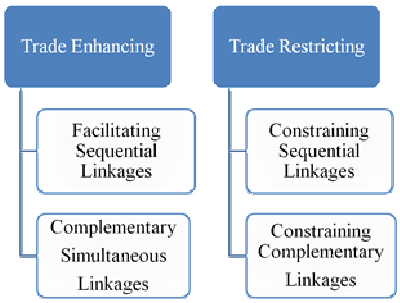
Annex 7. Trade in Health Services_Linkages across modes and sectors

Inter-modal Linkages



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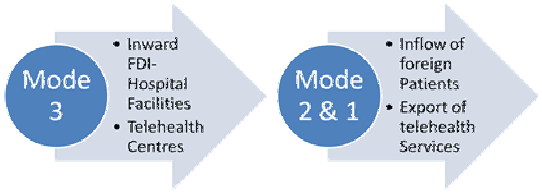
Inter-modal Linkages: Mode 3 as the Facilitating Driver



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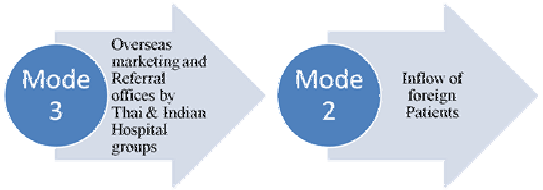
Inter-modal Linkages: Mode 3 as a Facilitating Driver



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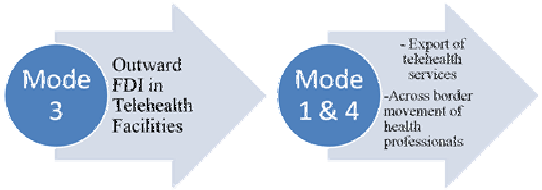
Inter-modal Linkages: Mode 3 as Facilitating Driver



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Inter-modal Linkages: Facilitating Complementary Linkages

- Treatment of foreign Patients at Apollo Hospital in Colombo (Mode 2) is complemented by fly-in-fly out doctors from India (Mode 4)

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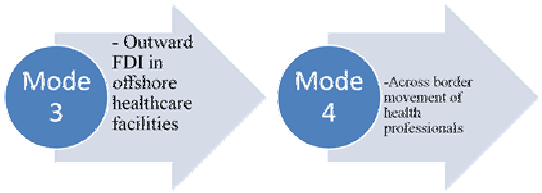
Inter-modal Linkages: Mode 3 as Complementary Driver



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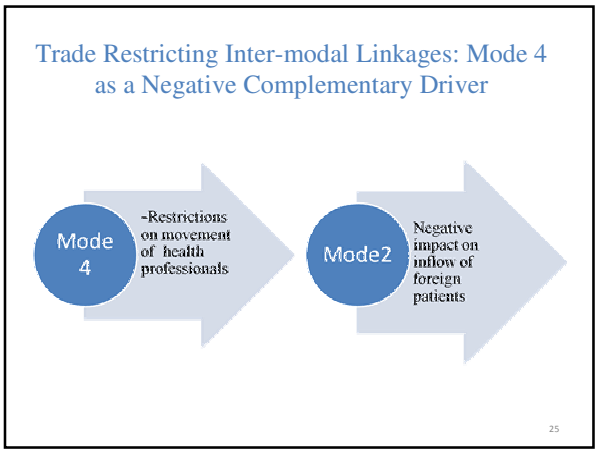
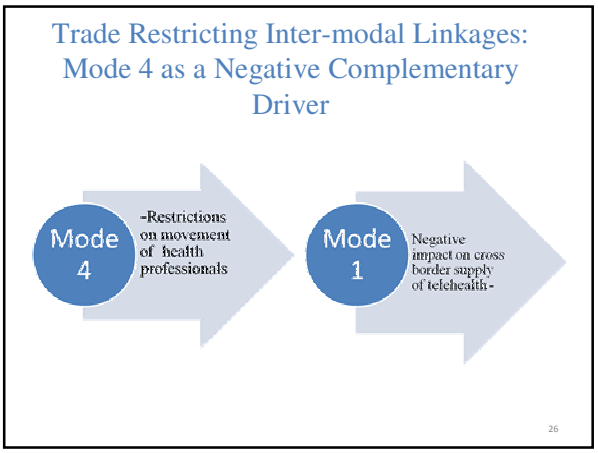
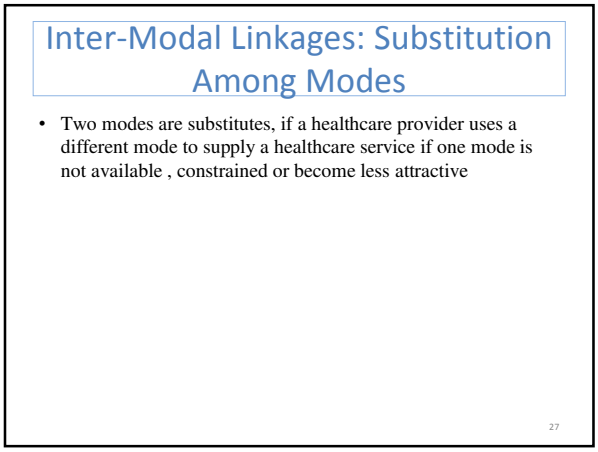
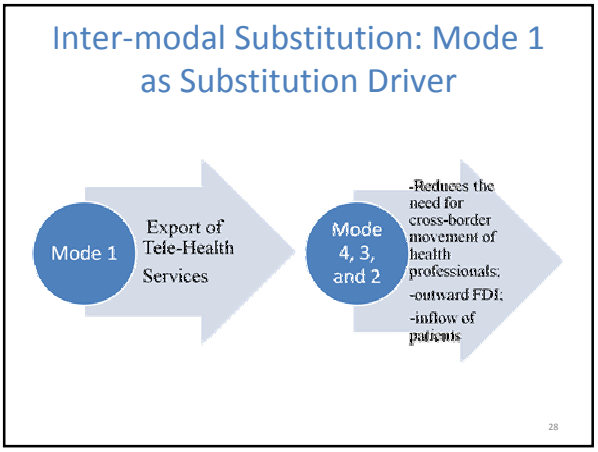
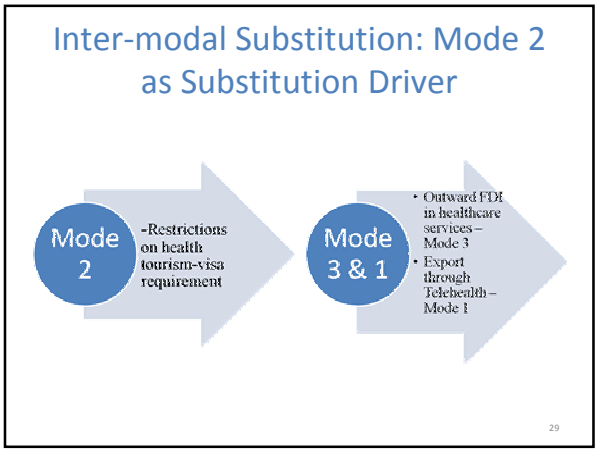
Annex 7. Trade in Health Services_Linkages across modes and sectors

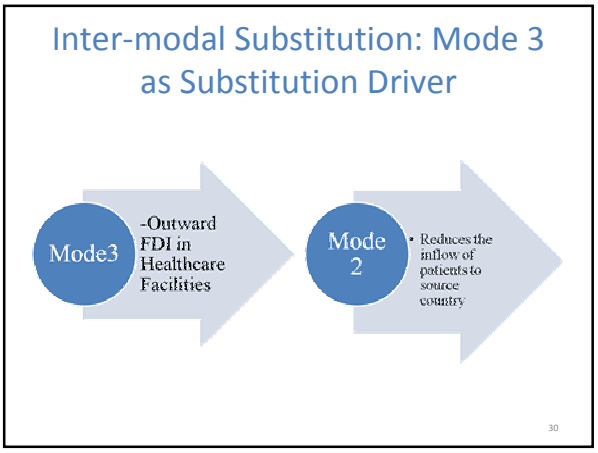




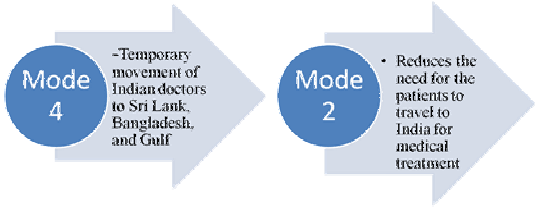








Inter-modal Substitution: Mode 4 as Substitution Driver



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Inter-Modal Linkages: Substitution Among Modes & Trade Effects

- Visa & travel restrictions on foreign patients (Mode 2) ➔
  - Increase export of healthcare services through Tele-health (Mode 1)
  - Increase Outward FDI (Mode 3)
  - Across border movement of health professionals (Mode 4)

➔Modes 1, 3, and 4 are potential substitutes for Mode 2

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Inter-Modal Linkages: How Substitution Among Modes Impact Trade in Healthcare Services?

- **Trade Expansion Substitution**: Substituting one or more modes (Mode 1, 3, 4) for Mode 2 can lead to Trade Expansion if
  - Increase in health services export via Mode (1, 3, 4) > drop in health services export due to restriction on Mode 2
- **Trade Contraction Substitution**:
  - Increase in health services export via mode (1, 3, 4) < drop in health services export due to restriction on Mode 2
- **Trade Neutral Substitution**:
  - Increase in services export via Mode 1, 3, 4 = drop in services trade due to restriction on Mode 2

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What Determines Substitutability Across Modes?

- **Technology**
  - Technological advances leading to surgical operations through remote controlled robots
  - Mode 1 substituting Mode 2, Mode 3 or Mode 4
- **Consumer Preferences**
  - Saudi patients preferring medical treatment in a American hospital in the US rather than the American hospital in Saudi Arabia due to their desire to have the "American experience".
- **Regulatory Environment**

- FDI restrictions in a foreign country (Mode 3) may lead to inflow of patients to home country (Mode 2) ➔ Mode 2 substituting for Mode 3

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Inter-modal Linkages in Healthcare Services : Some Observations

- Modes are not "perfect substitutes" for one another… second-best outcomes are conceivable
- Cost of providing the same healthcare service vary across different modes of supply
- A provider may choose to supply medical service is using all 4 modes of supply to reap "economics of scale " and "economies of scope"
- Health education & training ➔ face to face (Mode 2); on-line (Mode 1); Fly-in-Fly-out (Mode 4); Off-shore campus (Mode 3) ➔ A single provider will have a cost advantage

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Inter-modal Linkages in Healthcare Services: Some Observations

- Crucial to identify and support key facilitating mode of delivery …a mode that generates maximum positive externalities
- Important to identify and develop the channels through which the key mode enhances trade via other modes
- Maximise cross-sectoral positive externalities and minimise the negative ones

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Annex 7. Trade in Health Services_Linkages across modes and sectors

Identifying and Nurturing Key Trade Enhancing Mode

- Among the modes of supply, Mode 3 is more critical in terms of its impact on inter-modal linkages , trade creation, and its influence on inter-sectoral linkages
- Opening up the country for inward FDI in healthcare services (Mode 3) ➔ potential to generate export earnings through inflow of foreign patients (Mode 2) + export of Tele-health services (Mode 1)

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Supporting the Key Inter-modal Driver: Mode 3

- Liberal investment policies in healthcare services
- Conducive regulatory and competitive environment
- System of incentives to attract FDI in healthcare sector
- Liberal or no ceilings on foreign equity

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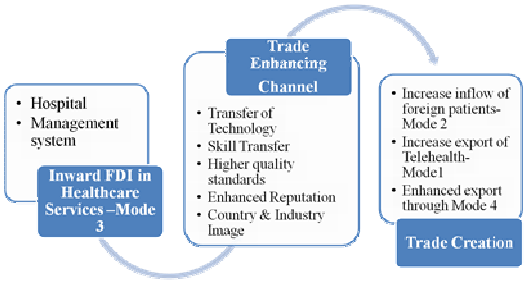
Facilitating the Channels that Maximise Inter-modal Positive Externalities



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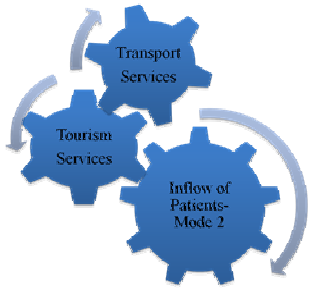
Inter-Sectoral Linkages



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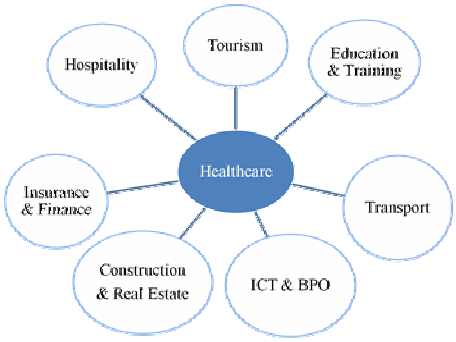
Trade in Health Services: Inter-Sectoral Linkages, Spillovers and Synergies: Growth, Income and Employment



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Concluding Thoughts

- Factors that will play crucial role in health services trade:
  - Quality and quantum of human capital
  - Services trade liberalisation and domestic reforms
  - Changes in global/regional demand and responsiveness to change
  - Market sector selection and resource deployment
  - Exploitation of inter-mode and cross-sectoral linkages
  - Emergence of efficient and value enhancing healthcare value chain involving inter-modal and cross-sectoral linkages

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Annex 8. Challeges in Tele-Health & Cross-border Supply & the Australian Context

Challenges in Tele-Health & Cross-border Supply & the Australian Context

Dr. Amir Mahmood
Associate Professor in Economics and International Business
Faculty of Business & Law
University of Newcastle, Australia

What is Tele-Health?

- Tele-Health ➔Integration of telecom systems into the practice of protecting and promoting health (Chanda, 2001)
- Tele-health ➔ A broad application of telecommunications in three areas: medicine, information, and education (Brauer, 1992)
- Telehealth ➔ The application of Information and Communication Technologies in medicine (Australian Telehealth Society)
- Telehealth ➔ The integration of telecom systems into the practice of protecting and promoting health
- Tele-health ➔ The utilisation of ever advancing telecommunication systems to address the range of health problems of distant patients (Mehryar and Narayan, 2007)

What is Tele-Health?

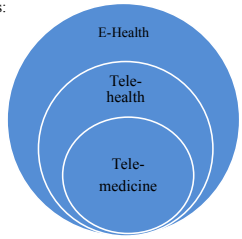
- Tele-medicine ➔ The use of electronic information and communications technologies to provide and support health care when distance separate the participants (Field 1996)
- Tele-medicine ➔ The facility to provide healthcare using telecommunications as the medium and modern medical technology as the tool. The delivery does't have to be in real time.(WTO)
- Tele-medicine ➔ The use of telecommunications technology to send data, graphics, audio, and video images between participants who are **physically separated** for the purpose of clinical care (Brecht and Barett, 1998)
- Tele-medicine ➔ Consultative, diagnostic or other medical services delivered via telecommunication technologies (Purcell)
- Tele-medicine ➔ Health related activities and services carried out over a **distance** by means of IT (Dacany et al, 2005)

How Tele-health links to e-Health and Telemedicine?

e-Health➔ the use of ICT in health sector for clinical, educational and administrative purposes, **both at the local site and at a distance.**

Telehealth ➔ application of ICT to provide (at a distance between two or locations) health-related activities such as:
-diagnostic and treatment services
-educational and support services
-Organisation and management of health services.

Telemedicine ➔ that subset of Telehealth that deals with medical diagnostic and treatment services.



What Drives the Growth of Tele-health Services?

- Advances in telecommunications technologies
- Increased separability of services from their production process
- Declining costs of electronic delivery
- Increased awareness & ease of use
- Reliability of tele-health systems
- Availability of ICT and medical infrastructure, resources, and competencies
- Resource deployment and market selection (medical transcription by India and the Philippines)

Telehealth Landscape in Developed and Developing Countries

Developed Countries	Developing Countries
• Advances in telecommunications technologies • Declining costs of electronic delivery • Ease of use • Reliability tele-health systems • Dominance of global medical sector • e-friendly business environment • Efficient e-health supply chain (payment procedure, delivery infrastructure, legal framework, quality assurance mechanism) • High connectivity • On-line medical education	• Low awareness, availability, and usage of tele-health services • Lack of telecommunication infrastructure • Indifferent business environment • Lack of resources at the enterprise and national level • Low connectivity • There are exceptions … Apollo Telemedicine and MedVarsity (Online medical education by Apollo)

Annex 8. Challeges in Tele-Health & Cross-border Supply & the Australian Context

Cross Border Supply of Tele-Health

- Telemedicine (e.g., on-line diagnosis)
- e-health education and training
- e-commerce and e-business applications for health management and health systems, data storage, and usage
- Use of IT in health management for better delivery and increased efficiency

Tele-health: Global Trends

- Increase demand for tele-diagnostic, surveillance, and consultation services provided by US hospitals to hospitals in Gulf and Central America.
- Provision of Tele-pathological services provided by Indian doctors to hospitals in Nepal and Bangladesh
- Tele-diagnosis services provided by hospitals in China's coastal provinces to patients in Chinese Taipei and Macao and some South East Asian countries.
- Outsourcing of Medical transcription which are being increasingly outsourced to developing countries such as India, Pakistan, and the Philippines
- Tele-health services provided by Australian providers in Indonesia and China

Cross-border Trade of Tele-health Services: Risks

- Data transmission, confidentiality and information security
- Professional responsibility
- Patients' rights and consent
- Reimbursements/payments
- Liability for negligence and abandonment
- Potential for fraud and abuse
- Secure access concerns

Cross-border Trade of Tele-health Services: Challenges

- GATS & Tele-health ---there are fewer commitments for Mode 1 than for any other mode
- Lack of established standards
- Cultural rigidities and mindset
- Organisational rigidities
- Technology
- Ethical & Privacy Issues
- Regulatory Issues
- Legal and insurance issues
- Diversion of resources from other health services
- Urban bias

Cross-border Trade of Tele-health Services: Challenges

- Inter-sectoral linkages between telecommunication network services, medical and non-medical professional services, and computers related services.
- Need to establish a standard of practice in tele-medicine to ensure:
  - Quality
  - Safety
  - Optimal patient care

Cross-border Trade of Tele-health Services: Key Barriers

Behavioural

- Resistance to telehealth – "fear that nurses are delegating tasks to machines"
- Lack of public awareness in developing world
- Change management – understanding the capabilities and limitations of the technologies and applying them appropriately.
- Lack of information technology knowledge and usage among healthcare professionals and clients
- Organizational, financial and attitudinal barriers to telemedicine adoption.

Annex 8. Challeges in Tele-Health & Cross-border Supply & the Australian Context

Cross-border Trade of Tele-health Services: Key Barriers

Financial

- Access to capital
- Payment issues/re-imbursement of telemedicine consultations
- Consumer affordability

Cross-border Trade of Tele-health Services: Key Barriers

Technological

- Electronic Health Record
- Lack of universal language for interfacing and interconnectedness
- Network infrastructure
- Lack of connectivity – broadband is not everywhere
- Network capability
- Home (client or provider) and office automation

Potential for Cross-border Trade of Tele-health Services: The Case Tele-radiology

- Reliability of the technology
- Quality of the images
- Speed of decision making
- Ability to have a specialist in one location to provide advice to generalist staff at another site
- Portability of the technology (radiologists just need a notebook and the Internet connection to receive images)
- Decline in the price of tele-radiology technology

Telehealth- The Australian Scene

- Distance
- Diverse spread of health resources, facilities, and patients
- Limited coverage
- Large country with small population
- Excellent but overstretched health system

Australian Tele-Health Landscape

- High levels of R&D expenditure and long established medical research institutes
- Globalised approach
- Specialised technical skills gathered from around the globe
- National E-Health Standards Development
- Government's National E-Health Strategy in December 2008
- Emphasis is universal connectivity

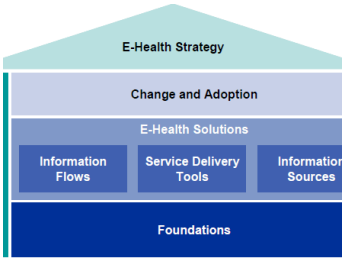
Key Players

- **NEHTA - National E-Health Transition Authority**
- **Australian e-Health Research Centre (**A joint venture between CSIRO and the Queensland Government, the Australian e-Health Research Centre is a leading national research facility in ICT for healthcare innovations)

Annex 8. Challeges in Tele-Health & Cross-border Supply & the Australian Context

Strategic Drivers of Tele-Health: Australia

- An ageing population
- A paradigm shift from treatment to prevention and care
- Changing models of care
- Expanding diagnosis and treatment options
- Improved information technology and communication
- Market forces
- Pressures to reduce healthcare costs
- Consumer demand
- Urbanisation and globalisation (National Telehealth Plan)



Australia's E-Health Strategy

The National E-Health Transition Authority Strategic Plan (2009-2012)

Strategic Priorities

- Developing the **essential foundations** required to enable e-health:
  - Healthcare Identifiers
  - Secure messaging and authentication
  - Clinical terminology and information service.
- Coordinate the progression of the **priority e-health solutions and processes**:
  - Referrals and discharge
  - Pathology and diagnostic imaging
  - Medications management.
- Accelerate the adoption of e-health.
- Lead the progression of e-health in Australia.

Telehealth in Australia: The Case of Statewide Telehealth Services

Telehealth in Australia: The Case of Statewide Tele-Health Services , Queensland

Innovative Approaches to Healthcare delivery

- Delivery of Post-surgery ear, nose, throat out-patient sessions
- Direct delivery of pre-admission assessment
- Wound management services in patients home via video conferencing using mobile phone
- Retinal (Eye) screening using digital fundus cameras
- Medical teams using telehealth services to provide advice on mental health, aged care, and paediatrics
- Use of videoconferencing, remote vital sign monitoring, delivery of pathology, and digital x-ray images to provide support to remote ICU units

Telehealth in Australia: The Case of Statewide Tele-Health Services , Queensland

Innovative Approaches to Healthcare delivery

- Development and use of mobile wireless videoconferencing to facilitate pharmacy consultation at the patient bedside
- Tele-rehabilitation services using real time videoconferencing, video recording, and still picture
- Collaboration with 3 Australian universities to develop real-time digital stethoscope
- Collaboration with Australian Universities to develop telehealth outcomes for intensive care and pre-admission assessment

Annex 8. Challeges in Tele-Health & Cross-border Supply & the Australian Context

Australian Export of Tele-Health Services

- Wireless health monitoring systems for screening, diagnosis and management of chronic diseases, and for consumer health and fitness
- Development of health informatics software for use in the management and surveillance of sexual health, communicable diseases, HIV/AIDS, hepatitis C, family planning and staff health occupational risk exposure
- Electronic medication management
- Hospital Software
- Telemedicine
- On-line medical education and training

Future of Tele-Health and Tele-Health Export in Australia: Some Concluding Remarks

- Health is a priority and a politically sensitive area …Connectivity is not
- Cost pressure and resource constraints will drive the implementation of e-health strategy
- Implementation of e-health strategy will make Australian health sector among the most telehealth-intensive health sector in the world
- A highly telehealth –intensive health sector is a necessary but not a sufficient condition to boost the Australian export of telehealth services
- The focus of telehealth initiatives in Australia is to achieve equity and efficiency and not to earn foreign exchange or generate revenue , e-health education & training remain an exception

Annex 9. Overview of Singapore's Biomedical Sciences Initiative

MINISTRY OF HEALTH
SINGAPORE

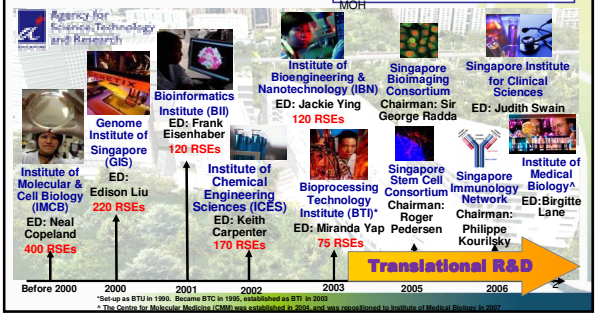
Overview of Singapore's Biomedical Sciences Initiative

Dr Loke Wai Chiong
Director
Health & Wellness Programme Office
Ministry of Health

From Basic Sciences to Translational R&D

2000-2005: Phase I of the Biomedical Sciences Initiative
- Focused on building a firm foundation for basic biomedical research

From 2006: Phase II of the BMS initiative
- Focuses on building strong capabilities in **Translational and Clinical Research (TCR)**
- Biomedical Sciences Review Committee identified 5 key disease areas to focus on
- $1.55B from MTI (A*STAR). NRF and MOH



*Set-up as BTU in 1990. Became BTC in 1995, established as BTI in 2003
^ The Centre for Molecular Medicine (CMM) was established in 2004, and was repositioned to Institute of Medical Biology in 2007

Promoting Translational and Clinical Research

3

From Bench to Bedside

Basic Research
Discover new knowledge & understanding of diseases
E.g. Understand molecular mechanisms of stroke

Investigational Medicine
Translate discoveries from lab to man, through animal models & proof of concept in man
E.g. Validate and test utility in man, of drug candidates, based on molecular mechanisms

Clinical Trials
Phase 1 (safety), **Phase 2** (efficacy & dosing), **Phase 3** (Cf. current best treatment)
E.g. Evaluate efficacy of drug candidate for regulatory approval

Health Services Research
Focus on effectiveness of procedures, devices, drugs and modes of care delivery
E.g. Assess if CT scan within 24 hrs of a stroke, can lead to improved outcome

Preventive Care / Public Health
Research on how to prevent patients from getting the disease
E.g. Assess environmental factors for stroke prevention

Strategy Map for BMS TCR Initiative

(4) Develop best **enabling resources** in Asia for translational research
(5) Strengthen **regulatory framework** for translational and clinical research.

Driven by EDB/Bio*One
INDUSTRY
Driven by multi-agency BMS Exco

BENCH
Key performers: A*STAR BMRC RIs, universities

Interaction strengthened by new entities arising from **hospital-medical school partnerships**

BEDSIDE
Key performers: MOH (viz. hospitals, specialist centres)

Develop **strong investigational med** capability
(2)
Be preferred site for **early phase clinical trials** in Asia
(6) Grow **health services, public health research**

(3) Establish **flagship programmes** from bench-to-bedside (heart/ metabolic, neuro, cancer, eye, infectious disease)

(1) Build critical mass of **human capital**, supernumerary to clinical service needs

Key Developments

(4) & (5) Developing **human biomedical research legislation**, master **intellectual property agreements**, established **Centre for Biomedical Ethics**. Supporting **Medical informatics** infrastructure underway.

Experimental Therapeutics Centre established

Strengthened Kent Ridge as "receptacle" for TCR – **NUHS** created; **Outram Campus** gearing up – Duke GMS started; restructuring underway

(6) Developing **Health Services** at MOH HQ; Duke GMS; NUS YLL

(2) Set up **S'pore Institute of Clinical Sciences**; Investing in **Investigational Med Units**;

(1) Established **STaR, CSA, MOH Research Scholarships**

(3) Awarded **TCR Flagship** grants – Cancer, neurosciences, eye, CV/metabolic and ID; **Grants portfolio** revamped – coherent, and larger scale; **New Capabilities** – SIgN, Imaging (CIRC); **Repositioning Existing Capabilities** – IMB (focus on TCR – stem cell, regenerative med)

Talent Development

- Build a critical mass of human capital for TCR which is supernumerary to clinical service needs of hospitals
  - Attract outstanding clinician-scientists from overseas
  - Encourage local clinicians to engage in clinical research
  - Develop strong pipeline of clinician-scientists and clinician-investigators

7

Support for Talent Development

- Singapore Translational Research (STaR) Investigatorship:-
  - Most prestigious clincian-scientists award
  - Modeled after the Howard Hughes Medical Institute Award
- Clinician-Scientist Award (protected time for research, 100% salary support)
- Healthcare Research Scholarship
- Establishment of Duke Graduate Medical School

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Clinical Research Infrastructure in Singapore

Investigational Medicine → Phase 1 → Phase 2 → Phase 3 → Phase 4, Epidemiology, HSOR studies

Investigational Medicine Unit At Kent Ridge Campus

Investigational Medicine Unit At Outram Campus

Singapore Clinical Research Institute (SCRI)

- Provides infrastructure, scientific leadership and core capabilities for conducting later stage clinical trials

SINGAPORE CLINICAL RESEARCH INSTITUTE

9

Marshalling Singapore's Translational Landscape

Translational Clinical Research (TCR) Flagship Programs

- Total of S$125M awarded over 5-years


Gastric Cancer
Genomics and biomarker trials


Ocular Surgery
Glaucoma & corneal disorders


Neurosciences
Schizophrenia & related psychoses


Metabolic Diseases
Developmental partnways


Infectious Disease
Dengue treatment & prevention

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Fostering Academic Medicine in Singapore

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Development of Academic Medicine

Developing Kent Ridge and Outram Campuses to serve as:-

- Receptacles that allow clinical service, medical education and research to be undertaken in an integrated way
- Environments where clinicians work closely with researchers and educators
- Platforms to translate basic science discoveries into new applications for patients

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AMC Development at Kent Ridge Campus

- National University Hospital (NUH) and National University of Singapore (NUS) departments integrated to function as single National University Health System (NUHS) departments across clinical service, education and research activities
- Integrated NUHS-wide processes, e.g. strategic planning, HR, procurement, budgeting

NUHS
National University Health System

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AMC Development at Outram Campus

- Joint decision-making (cross-institutional representation on governing boards/committees)
- Joint human capital development (clear career tracks for clinician-scientists/educators; joint academic appointments)
- Shared research facilities

Changi General Hospital
KK Women's and Children's Hospital
Singapore General Hospital
Polyclinics SingHealth
National Cancer Centre Singapore
National Dental Centre
National Heart Centre
National Neuroscience Institute
Singapore National Eye Centre
SingHealth
DUKE NUS GRADUATE MEDICAL SCHOOL SINGAPORE

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MINISTRY OF HEALTH
SINGAPORE

Thank you

Back-up slides

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Background

- 2000-2005 – Phase I of the Biomedical Sciences Initiative
- June 2006 – Singapore Government decided that translational & clinical research (TCR) will be a key focus of BMS Phase II development
  - Biomedical Sciences Review Committee identified 5 key disease areas to focus on
  - **$1.55B** from MTI (A*STAR), NRF and MOH
- Clinical research was included as part of MOH's mandate
  - Key outcome: Better healthcare delivery for the public

17

Integrated Biomedical Sciences Initiative

Phase 2: 2006 - 2010

Research, Innovation & Enterprise Council (RIEC)
Chaired by PM Lee Hsien Loong

Steering Committee for Life Sciences (SCLS)
Dy Chmn RIEC / Chmn NRF, Ministers for Trade & Industry, Health, Education, and Community Development, Youth & Sports

Biomedical Sciences Executive Committee
Co-chaired by Chairman, A*STAR & Permanent Secretary (Health)

BMS International Advisory Council (BMS IAC)

Intellectual Capital WG | **Human Capital WG** | **Infrastructure Capital WG**

Biomedical Research Council (BMRC), A*STAR
(Chmn: Sir George Radda)

National Medical Research Council (NMRC), Ministry of Health
(Exec Chmn: Prof Edward Holmes)

18

Research Grants

STRATEGIC/PROGRAMMATIC:

•Translational & Clinical Research Flagship Programs (S$25 m each)

Gastric Cancer (Genomics and biomarkers trials)
Neuroscience (Schizophrenia & related psychoses)
Eye Diseases (Glaucoma and corneal disorders)
Infectious Disease (Dengue treatment and prevention)
Metabolic Diseases (Developmental pathways)

- Programmatic Project Grants
- Centre Grants

INVESTIGATOR-LED RESEARCH:

- Individual Research Grants
- Exploratory / Developmental Grants
- New Investigator Grants

19

Investigational Medicine Unit (IMU) – Kent Ridge Campus

Facilities

18 beds

NUHS National University Health System

A/Prof Goh Boon Cher
Director, Investigational Medicine Unit

Core Capabilities

- **Cardiovascular Imaging Core Laboratory: Cutting-edge echocardiographic and vascular imaging**
- **Genomics Core Laboratory: Analysis of DNA, RNA and protein-based biomarkers in body fluids, frozen / archival tissues, and culture and environment isolates**
- **Clinical Pharmacology Group: Provides expertise and consultation for both pharmaceutical industry and investigator-initiated translational and clinical projects**
- **Clinical Biostatistics and Pharmacometric Unit : Provides biostatistical, data management and computing capabilities to support clinical trials**
- **Pharmacokinetics & Pharmacodynamics Analytical Laboratory: Provides quality bioanalytical service to quantify the active drug and / or its metabolite(s) in different biological matrices according to FDA Guidance**

Confidential

Investigational Medicine Unit (IMU) – Outram Campus

Facilities

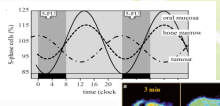
30-bed, and a 2-bed Chronobiology Lab

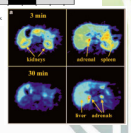
SingHealth

A/Prof Tal Burt
Director, Investigational Medicine Unit

Core Capabilities

- **Phase 0 / Microdosing**
- **Chronobiology: Investigate the effect of circadian rhythm on drug metabolism e.g. Circadian-Based Delivery of 5-FU**





International Collaboration

- **Access to network of experts** through strategic partners
- E.g. Duke University Medical Center in the US, Duke Clinical Research Unit (DCRU), Clinical Research Institute (University of Kansas)
- Biometrics support in study design, implementation, analysis, interpretation and reporting of clinical trials)

Confidential

21

Private Translational and Clinical Investments

Translational Labs

- 100 FTEs at steady state
- Biomarker research lab
- In-house Ph 1 pharmacological unit

- 21 FTEs
- Focus on tissue analysis, biomarker discovery and cancer research
- Chugai-Biostar (Mitsui/CIEA) JV

- 150 FTEs
- Oncology biomarker research & genomic data analysis
- Drug Hunting Teams for cancer and metabolic diseases

Clinical Activities

- First in human Phase 1 trials
- Conducted in partnership with local investigators and hospitals
- ABT 869 trial: Study completed in 12 mths to highest data standards, before patient recruitment completed in other 2 sites; new indication identified

- US$550 mil license agreement with Onyx for JAK2 inhibitor
- US$112.5 mil license agreement with Tragara for multi-kinase inhibitor SB1317

- Phase 1 Unit
- 50-man team, 31 beds
- 15 studies/yr
- Only unit in outside US

- Phase 1 Unit
- 70-man team, 54 beds
- 40 studies/yr
- Only unit in Asia

Clinical Trial Coordination

Supporting Svcs

- 50 FTEs
- NHP and mouse CRO
- Partnerships with major pharma on efficacy models
- Small and large animal imaging capability

Public Sector Services available to companies

- Biological Resource Centre: 10,000 sqm Animal facility with breeding and husbandry services, at SPF and non-SPF standards
- Translational Research Interface: Sample collection, tissue preparation and biomarker analysis
- Tissue Repositories at public hospitals

Annex 10. Medical Health Travel and Wellness_Case of the Philippines

Medical Health Travel and Wellness

Presentation of
Ruy Y. Moreno
Director for Operations-Private Sector
National Competitiveness Council
PPP Task Force on Globally Competitive
Philippine Service Industries
Committee on Health and Wellness

APEC SEMINAR ON TRADE IN HEALTH SERVICES
MACTAN SHANGRI-LA, CEBU
FEBRUARY 9, 2010

Investment Climate

- ✓ Competitive Investment Incentives
- ✓ Readily Available and Qualified Workforce
- ✓ Experienced and Good Supervisors
- ✓ Globally Competitive Senior Managers & Executives

Two Types of Medical Health Travelers

Those who go to the Philippines solely for world-class, cost-competitive healthcare services…

Two Types of Medical Health Travelers

…And those who take advantage of the Philippines' wide array of tourist and leisure attractions while experiencing those world-class, cost-competitive healthcare services.

Healthcare and Tourism, a winning combination in the Philippines

- **Competitive medical services and world-class facilities:**
  - Comprehensive integrated packages of medical and health services tailored for special groups or individuals
  - Cost competitive medical and surgical procedures
  - High standards of medical care and top notch healthcare professionals
  - State-of-the-art technology and facilities
- **Ideal travel destination:**
  - High level of English proficiency
  - Favorable exchange rate
  - Ease of travel from the U.S.
  - Strategic location in Southeast Asia
  - Wide variety of tourist attractions

Philippine Medical Capacity

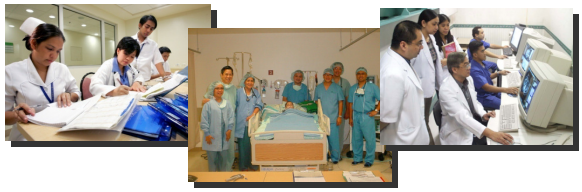
A selection of accredited, state-of-the-art hospitals:

- Asian Hospital & Medical Center
- Capitol Medical Center
- Makati Medical Center
- Manila Doctors Hospital
- Medical Center Manila
- National Kidney & Transplant Institute
- Philippine Heart Center
- St. Luke's Medical Center
- The Medical City

Full range of specialized services, including:

- Cardiovascular
- Cancer
- Neuroscience
- Organ Transplantation
- Orthopedics
- Aesthetic surgeries

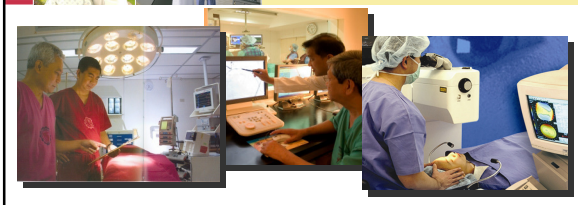
Philippine Medical Professionals



109,043 - Total number of registered doctors*
413,047 - Total number registered nurses*
74,025 - Other registered medical professionals*

Figures as of December 2006

Philippine Medical Professionals



- Deep pool of Internationally-trained physicians
- Expertise in state-of-the-art technology
- Extensive experience in treating local and foreign patients

Full Range of Medical Treatments and Services

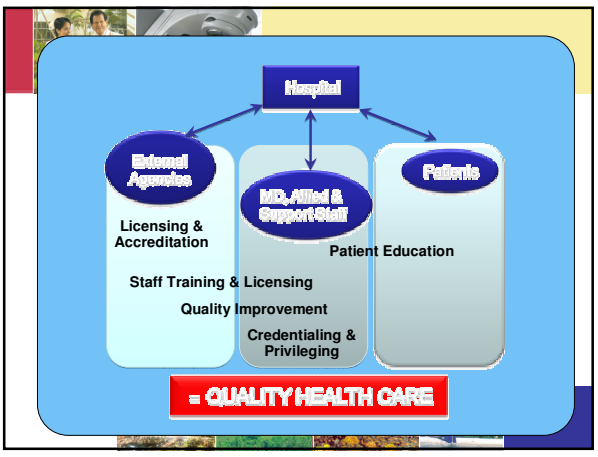
- ✓ Medical check-ups, Sleep disorders, Joint replacement surgery, Kidney and Urologic care, Cancer diagnosis and treatment, Digestive and liver disease management, Stereotactic radiosurgery, Neurosurgery, Transplants, Cardiac care and Heart surgery
- ✓ Plastic & Reconstructive Surgery, Bariatric Surgery, Eye Care and Treatment (LASIK/LASEK/PRK), and Dental Care and Treatment
- ✓ Physical Medicine and Rehabilitation, Sports Medicine, Cardiac rehabilitation

Significant Cost Competitiveness

Procedures	Cost Savings (%)
Coronary Bypass	50% - 80%
Total Hip Replacement	50% - 80%
Lasik	50% - 80%
Liposuction	50% - 80%

Significant Cost Competitiveness

Accommodations	Cost Savings (%)
Private Room	30% - 50%
Suite	30% - 50%



MD Credentialing and Privileging

- Credentialing – systematic approach of assessing an MDs professional competence and conduct, including a review of relevant academic training, experience, licensure, certification, and/or registration to practice.
- Privileging – process by which a hospital determines what procedures may be performed and/or which conditions may be treated by each physician, based on his established qualifications.
- Hospital C & P mechanisms ensure the continuing technical proficiency of and adherence to ethical standards by its MDs, and hence promote the quality and safety of patient care.

Quality Improvement Programs

- QI programs are systematic efforts to design, document, implement, monitor/measure, and continually improve the effectiveness of hospital processes
- QI Programs may be driven by:
  - External Regulatory Agencies (e.g. PHIC)
  - Private Sector Collaboration (e.g. PSQua)
  - Individual Hospital Initiative
- Examples of QI Programs/Mechanisms
  - Peer Audits
  - Sentinel Event Monitoring
  - Tracking of Hospital Quality Indicators
  - Quality Circles

Patient Education Programs

- Patient Education Programs empower patients to demand service quality and safety
  - Through Information / Education
  - Through Creation of Venues for Active Engagement in Care Process
- Examples of Patient Education Programs
  - Patient Education Materials
  - Individual Counseling
  - Group Classes
  - Patient Rights Programs

Hospital Quality Indicators

Infection Rate	*INICC Low	*INICC High	Sample Phil Hosp
Foley Catheter-Associated Infection	1.7	12.8	1.9
Blood Stream Infection	7.8	18.5	8.9
Ventilator-Associated Infection	10.0	52.7	13.2

* *International Nosocomial Infection Control Consortium*

HEALTH & WELLNESS

17

The world is changing…

1700s - agriculture

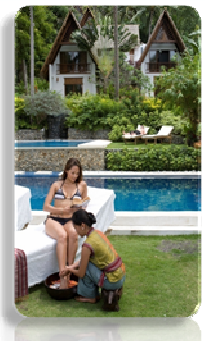
1800s – steel, trains

1900s – manufacturing, cars

2000 – information, computers

2010 – psychosocial, health concerns

"The Wellness Revolution"



Why Wellness ?

19

Modern living makes healthy living difficult, if not impossible to attain…

20

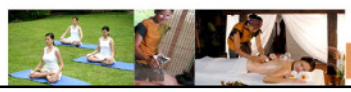
- Stress is a major cause of sickness and death: Millions of people world-wide get sick and die every year due to stress-related illnesses and faulty nutrition like obesity, diabetes, hypertension, high blood pressure

21

SICKNESS IS EXPENSIVE…
….VERY EXPENSIVE!

22

GETTING SICK
IS ALSO RISKY….



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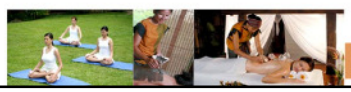
The Future Lies in Self-Responsibility



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WELLNESS DEFINED

- HEALTH – "Being established in the self" (Ayurveda)
- DISEASE – "Being disconnected from the self"
- TRADITIONAL CHINESE MEDICINE – when your life is out of balance, illness results

25

"Giving an experience of wellness is giving an experience of connectedness"

Dr.Marc Cohen

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"SENSES" MODEL

(By Dr. Marc Cohen)

S - STRESS MANAGEMENT

E - EXERCISE

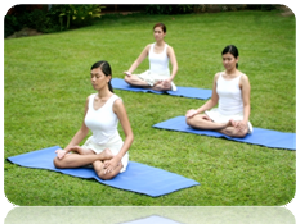
N - NUTRITION

S - SOCIAL

E - EDUCATION

S - SPIRITUAL

PILLARS OF WELLNESS



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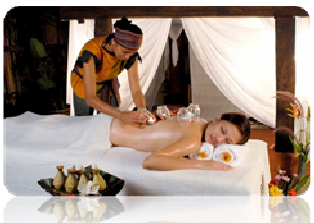
"SPAS WILL BE THE CENTERS OF CONNECTIVENESS & WHOLENESS"



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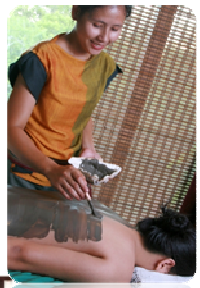
Benefits of Spa Therapies

- THE STRESS HORMONE, CORTISOL, SLOWS DOWN TO NORMAL LIMITS
- CIRCULATION IS IMPROVED. BLOOD FLOW THAT CARRIES OXYGEN & NUTRIENTS TO THE TISSUES IS ENHANCED



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Benefits of Spa Therapies

- METABOLISM IS STIMULATED, WHICH HELPS WEIGHT LOSS
- BETA-ENDORPHINS-NATURAL "HAPPINESS" HORMONES ARE RELEASED
- DETOXIFICATION THROUGH THE SKIN, KIDNEYS & LIVER IS IMPROVED

SPAS HELP PEOPLE…

….LOOK WELL
….FEEL WELL
….PERFORM WELL
….& STAY WELL

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FUTURE SPA DEVELOPMENT

- New interest in spas with a medical orientation
- The future hospital will be spa oriented, especially hospital for affluent
- Family spas are growing in Europe and United States.
- More of "Eastern Medicine".
- Aging baby boomer market
- Baby boomers and their generation X children cry out for holistic, medical approaches and preventative holistic modalities.

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Philippines' Unique Care Giving Culture

- Wellness and Prevention
- Wellness- a healing and preventative measure vis-à-vis complex healthcare events

  Manila Doctors, Medical City, St. Luke's, Chong Hwa Hospital, Nurture Spa Village-Tagaytay

33

Enhanced Investment Climate

- Care Giving culture of the Country
- Interdisciplinary approach to expert medicine and care giving
- World-class medical facilities
- Internationally trained and recognized physicians and nurses
- Spa attendants – trained to European and international standards
- Value for money- patient safety and quality

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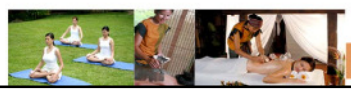
Enhanced Investment Climate

- International Accreditation Standards, ex. Accreditation Canada (AC), Joint Commission International (JCI)
- Insurance portability



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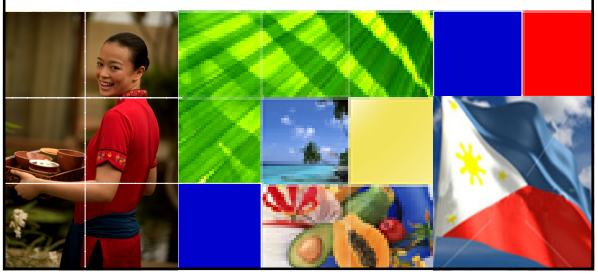
Mabuhay!

Ruy Y. Moreno
National Competitiveness Council
e-mail: rymoreno2004@yahoo.com
www.competitiveness.org.ph



APEC Trade in Health Services Seminar
Mactan, Cebu
9-11 February 2010

Workshop Guidelines

Objectives:

The workshop sessions are meant to:

- provide an opportunity for all participants to contribute their views on the topics and issues discussed during the seminar, as well as other concerns in the area of trade in health services;
- generate a common understanding (not necessarily consensus) of the main issues (opportunities and challenges in trade in health services; risks to national health systems and possible mitigating measures) related to trade in health services; and, equally important, of the risks posed by trade in health services to national health systems;
- provide a venue for participants to discuss, prioritize, and agree on possible cooperation projects that respond to actual needs and provide tangible benefits; and,
- impel participants to commit to specific, measurable action plans in support of the cooperation projects.

Mechanics:

The participants will be heterogeneously grouped into four (4), allowing for optimal diversity in each group. The groupings will be posted / announced during the afternoon coffee break of February 9. Each group will be asked to concentrate mainly on a particular Mode of Supplying Health Services. However, as the modes are inter-linked, groups may also discuss their specific mode's implications on the other modes. (Please see attached note for a brief discussion of the Four Modes of Supplying Health Services)

The four groups are as follows:

- Group 1: Cross-border Trade (e.g. tele-health)
- Group 2: Consumption Abroad (e.g. medical travel)
- Group 3 : Commercial Presence (e.g. foreign investments)
- Group 4: Movement of Natural Persons (e.g. temporary migration of health professionals)

Each group should appoint a discussion leader (to facilitate the flow of the group discussion and to ensure that all members participate in the exchange of ideas) and a rapporteur (to document the highlights of the group discussion).

At the start of each day, the groups will be given 10 minutes to present the highlights of their workshop discussions. The groups are free to choose their presentors, as well as the manner of presenting (e.g. thru powerpoint, flipcharts, etc.)

Workshop 1: February 9

Mode	Recommended Guide Questions
1: Cross-border Trade (e.g. tele-health)	• What types of health and health-related services can be transmitted across countries via the internet, the telephone or mail service? (e.g. eHealth or tele-health) • What factors facilitate or impede the transmission of these services across borders? [e.g. policies and regulatory requirements (data privacy laws), processes and practices, technology, etc.)] • What challenges and opportunities does this type of trade in health services present to APEC members? How can it affect national health systems, especially in terms of access of marginalized sectors to quality, affordable health care? • What can you do to ensure that trade in health services positively affects local health systems?
2: Consumption Abroad (e.g. medical travel)	• What types of health and health-related services are typically delivered via medical travel? • What factors facilitate or impede patients from traveling to other countries for purposes of seeking health services? • What factors facilitate or impede health service providers or institutions from providing services to foreign patients? • What challenges and opportunities does international medical travel/tourism present to APEC members? How can it affect national health systems, especially in terms of access of marginalized sectors to quality, affordable health care? • Are there health-sector related problems which can either be alleviated or worsened by encouraging the entry of medical tourists? • What can you do to ensure that trade in health services positively affects local health systems?
3: Commercial Presence	• What types of health and health-related services and facilities typically receive foreign investments? • What factors facilitate or impede health service providers from seeking additional resources through foreign investments? • What factors facilitate or impede investors from investing in health-related services and facilities in other countries? • What challenges and opportunities do foreign investments in health services and facilities present to APEC members? How can foreign investments affect national health systems, especially in terms of access of marginalized sectors to quality, affordable health care? • Are there health-sector related problems which can either be alleviated or worsened by encouraging the entry of foreign investments in the health sector? • What can you do to ensure that trade in health services positively affects local health systems?

4: Movement of Natural Persons	• What types of health and health-related services typically require temporary migration foreign health professionals? • What factors facilitate or impede health professionals from migrating to other countries? • What factors facilitate or impede health facilities and institutions from recruiting foreign health professionals? • What challenges and opportunities does migration of health professionals present to sending (originating) and receiving (destination) APEC members? How can migration of health professionals affect national health systems, especially in terms of access of marginalized sectors to quality, affordable health care? • Are there health-sector related problems which can either be alleviated or worsened by encouraging the migration of health professionals? • What can you do to ensure that trade in health services positively affects local health systems?

Workshop 2: February 10

Guide Questions:

1. With all the points raised in this seminar (from the presentations, to the discussions, to the workshops, to the networking, etc.) what do you think are the main issues related to international trade in health services? Please identify at least three issues.

2. Individually reflecting on these issues, what do you think does your country need to better address these issues? What do you think can your country offer to assist other countries better address these issues? (e.g. technology, information and data, expertise and experience, etc.)

3. Matching the APEC members' needs and resources (e.g. technology, information and data, expertise and experience, etc.), what specific cooperation projects can be pursued? Please identify at least two.

4. Please identify the specific actions (action plan) needed to pursue these projects, indicate the timetable, responsible persons or institutions, and resource needed.

Technical Note to the Workshops: Four modes of supplying health services internationally

The multilateral environment for trade in services is governed by the General Agreement on Trade in Services (GATS). The GATS, together with the General Agreement on Tariffs and Trade (GATT) and the Agreement on the Trade-Related Aspects of Intellectual Property Rights (TRIPS), is part of the Marrakesh Agreement that established the World Trade Organization (WTO) in 1995.

The GATS also defines four ways in which a service can be traded, known as the *four modes of supplying services*:

- Mode 1 – refers to services supplied from one country to another (e.g. international telephone calls), officially known as "crossborder supply";
- Mode 2 – refers to consumers from one country making use of a service in another country (e.g. tourism), officially known as "consumption abroad";
- Mode 3 – refers to a company from one country setting up subsidiaries or branches to provide services in another country (e.g. a bank from one country setting up operations in another country), officially known as "commercial presence"; and
- Mode 4 – refers to individuals traveling from their own country to supply services in another (e.g. an actress or construction worker), officially known as "movement of natural persons".

In terms of health services, it is useful to illustrate the four modes of supplying services by citing the example of a doctor providing a service to a patient. What are the ways by which a doctor can provide a service to a patient? Normally, the patient goes to the doctor for consultation. However is it still possible to provide health services if the patient lives in Country A and the doctor lives in Country B?

To supply the doctor's service internationally, the most basic way is for either the patient to go to Country B—which is called Consumption Abroad (mode 2); or for the Doctor to go to the patient in Country A—known as Movement of Natural Persons (mode 4).

Another way is for the doctor to invest in a hospital in Country A, such that even if the doctor himself or herself is not the one providing the service, it is provided by his / her agent (i.e., a hospital owned by the doctor). This is called Commercial Presence (mode 3).

In recent years, however, with advancements in ICT, more and more services are provided alternatively. The patient may undergo some diagnostic procedure in his/her home Country and then the results may be digitized and sent over the internet to the doctor in Country B; the doctor then provides his medical diagnosis of the patient's condition via the internet. This is known as cross-border trade (mode 1), where neither the patient nor the doctor—nor his / her agent—leaves their respective countries. Although these could already be done before (i.e., by physically sending the x-ray plate through courier services), it was previously too time consuming and expensive to be viable.

Supplying Health Services Internationally:

Case of a Patient living in Country A and Doctor living in Country B

	Country A: Patient		**Country B: Doctor**
Mode 1: Cross-border Trade	Patient stays in Country A; has his X-ray taken.	X-ray result is digitized and sent via the internet	Doctor stays in Country B, retrieves digitized X-ray from the internet and sends his diagnosis to patient (also via internet)
Mode 2: Consumption Abroad			Patient travels to see Doctor in Country B
Mode 3: Commercial Presence	Patient stays in Country A; goes to a hospital owned by the Doctor (from Country B).	Doctor invests in hospital in Country A.	Doctor stays in Country B.
Mode 4: Movement of Natural Persons	Patient stays in Country A; Doctor travels to Country A to treat the Patient.		

APEC Seminar on Trade in Health Services
9-11 February 2010
Cebu, Philippines

WORKSHOP 1
" Barriers and Opportunities on Trade in Health Services"

GROUP 1: **MODE 1 - CROSS BORDER TRADE (e.g. Tele-health)**
MODE 2 - CONSUMPTION ABROAD (e.g. medical travel)

VENUE: **MACTAN BALLROOM 2**

Facilitator/Moderator: Mr. Michael Lyndon Garcia and Ms. Twinkle Rodolfo
Rapporteur: Dr. Allan Evangelista

Members:

Ms. NORAINI MANAP (BRUNEI)
MS. BAI XUE (CHINA)
MR. MOHD RIDHA MOHSIN (MALAYSIA)
DR. LOKE WAI CHIONG (SINGAPORE)
DR. SONGPHAN SINGKAEW (THAILAND)
MS. NGUYEN THUY PHUONG (VIETNAM)
MS. MAYLENE BELTRAN (PHILS)
ATTY. GENESIS ADARLO (PHILS)
MS. JOYCE CIRUNAY (PHILS)
MS. EMILY ESCASINAS (PHILS)
MS. LAURITA MENDOZA (PHILS)

APEC Seminar on Trade in Health Services
9-11 February 2010
Cebu, Philippines

WORKSHOP 1
"Barriers and Opportunities on Trade in Health Services"

GROUP 2 : MODE 3 - COMMERCIAL PRESENCE (e.g. foreign investment)
MODE 4 - MOVEMENT OF NATURAL PERSON (e.g. temporary migration of health personnel)

VENUE: MACTAN BALLROOM 3

Facilitator/Moderator: Dr. Kenneth Ronquillo and Dr. Anthony Calibo
Rapporteur: Ms. Georgina Ramiro

Members:

DR. WADI HANA SUDIN (BRUNEI)
MR. GAO XINGQUIANG (CHINA)
MS. NURUL ADNI ZAINUL ARIFF (MALAYSIA)
MS. WEI NA TAN (SINGAPORE)
DR. VEERACHAT PETPISIT (THAILAND)
DR. NGUYEN MANH CUONG (VIETNAM)
ATTY. NICOLAS LUTERO (PHILS)
MS. MARGARET BENGZON (PHILS)
MS. ESPERANZA MELGAR (PHILS)
MS. MILLICENT JOY URGEL (PHILS)
MS. CRISPINITA VALDEZ (PHILS)

Annex 12. APEC Seminar on Trade in Services: Highlights of Day 1 (February 9, 2010)

APEC Seminar on Trade in Health Services:

Highlights of Day 1 (February 9, 2010)

Maria Cherry Lyn S. Rodolfo

1

Topics

- Frameworks (Ms. Karin Timmermans, WHO)
  - General Agreement on Trade in Services
  - Trade in Health Policy Took Kit
- Linkages (Prof. Amir Mahmood)
- Trade facilitation (Prof Mahmood, Dr. Loke Wan Chiong, Mr. Ruy Moreno)
  - Cross-border Tele-health
  - International Medical Travel

2

Critical Issues and Challenges

3

Frameworks

- Complexity of GATS and toolkit (framework not self-explanatory)
- Lack of capacity to understand and assess:
  - Trade-offs between efficiency and equity
  - Benefits from trade as an exchange process and not as profit vs loss process
  - Impact of trade liberalization on public health
  - Separability of issues in trade in health-related goods and services (diagnostic tool) while at the same time recognizing interdependence
- Measurement issues (i.e. definition of terms, data limitations, indicators to be used)
  - For example, cost competitiveness data may not be comparable
  - Comparative advantage (national level competitiveness) is different from competitive advantage (facility level)
- Lack of safety nets to address issues on ethics, equity and standards

4

Linkages

- Modes are not "perfect substitutes" for one another… second-best outcomes are conceivable
  - Medical tourism will not completely solve massive migration of health professionals
- Important to identify and develop the channels through which the key mode enhances trade via other modes
  - ICT policies in aid of tele-health development
  - Air transport and immigration policies to support moblity of international medical travel
- Maximise cross-sectoral positive externalities and minimise the negative ones
  - Foreign investments in healthcare facilities lead to technology transfer, higher standards, better skills, better image and reputation
  - These effects then translate to increased income streams from international medical travel, tele-health exports

5

Trade Facilitation

- Lack of capacity to handle liabilities and risks
- Issues with standards (e.g ethics, quality, accreditation)
  - Lack of resources to develop, improve and monitor and regulate standards
  - Lack of mutual recognition of standards and resources to comply with agreed standards
- Lack of region-wide mechanism to facilitate portability

6

Challenges for APEC

- Capacity-building among public health ministries
- Greater interaction between public health and trade sector especially in implementing the diagnostic tool
- Development and mutual recognition of standards
- Development of complementary policies in aid of maximizing benefits from positive linkages among modes of trade

7

Thank You!

8

Borderless Medical Travel in APEC

Todd Nissen
Office of the United States Trade Representative

Cebu, Philippines
February 10, 2010

1

Medical travel in APEC, formerly

2

Healthy and growing industry

- Thailand (2005):
  - 1.28 million visitors
  - $US 1 billion
- Malaysia (2006)
  - 300,000 visitors
  - $US 59 million
- Singapore (2006)
  - 410,000 visitors

Deloitte Consulting, Medical Tourism: The Asian Chapter, 2008

3

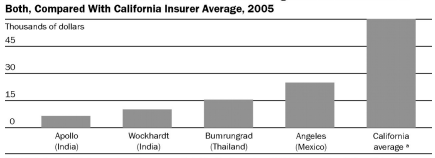
Why?

- Increased mobility
- More globalized workforce
- Increased demand for outpatient surgery (35 million in U.S. alone in 2006)
- Few restrictions
- And of course . . .

4

Cost

EXHIBIT 2
Combined Average Expected Hospital And Professional Fees For Elective Coronary Artery Bypass Graft (CABG) Procedures At Offshore Hospitals That Have Obtained Joint Commission International Or International Standards Organization Certification Or Both, Compared With California Insurer Average, 2005

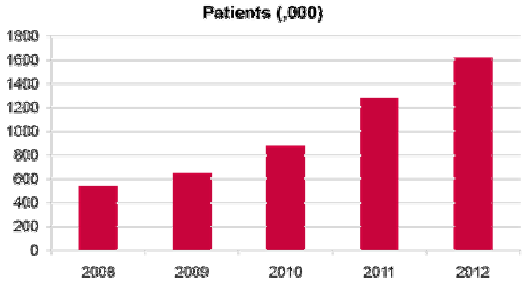


SOURCES: Hospital telephone and e-mail responses during the fourth quarter of 2005 from each hospital's self-identified contact for U.S. customer inquiries; California comparison was average allowable total payments per CABG reported in the fourth quarter of 2005 by a very large preferred provider organization (PPO) insurer for the prior year and then adjusted to offset the estimated higher cost of emergency CABG procedures via analysis of California's Office of Statewide Health Planning and Development (OSHPD) database.
[a] Analysis by Thomson Medstat of its more limited California claims database demonstrates that more-efficient California hospitals would compare more favorably. Average fees at its twenty-fifth-percentile-ranked hospitals, ranked on allowable fees, were 25 percent lower than average California fees. However, a large offshore fee advantage persists.

Arnold Milstein and Mark Smith, Will The Surgical World Become Flat?, Health Affairs, Vol 26, Issue 1, 137-141

5

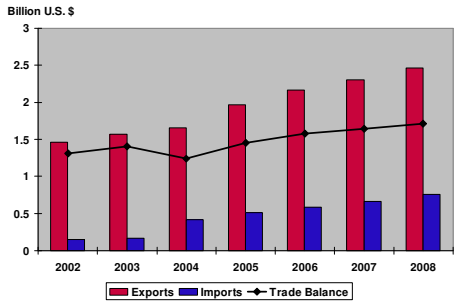
Projection of U.S. outbound medical tourism



Deloitte, Medical tourism: Update and implications (2009)

6

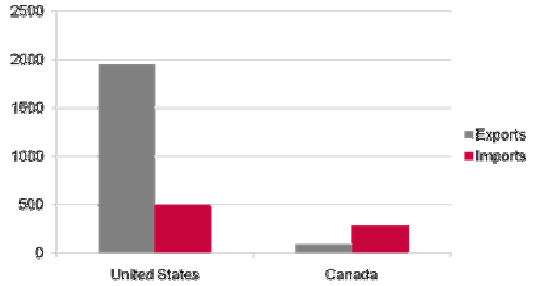
U.S. mode 2 medical services trade



U.S. Bureau of Economic Analysis, U.S. International Services: Cross-Border Trade 1986-2008

7

2005 Mode 2 Trade in Medical Services



BEA and OECD Stat

8

Economy-wide benefits

- If one in ten U.S. patients who need one of fifteen highly tradable, low-risk treatments went abroad, the annual savings for the United States would be $1.4 billion.
- Every 10 percent reduction in excess health care cost growth—a decrease in cost growth from 2.2 percentage points above GDP to 1.98 percentage points—leads to about 120,000 more jobs

Mattoo and Rathindran, How Health Insurance Inhibits Trade in Health Care, 2006
Sood et al.,"Employer-Sponsored Insurance, Health Care Cost Growth, and the Economic Performance of U.S. Industries," 2009

Facilitating medical travel

- Quality assurance
  - Joint Commission International (JCI) approved sites: 76 in 2005 to more than 220 in 2008.
  - Accreditation important mechanism for building confidence, credibility

10

Facilitating medical travel

- Quality assurance
- Networks facilitated by open investment
  - U.S. teaching hospitals - Johns Hopkins, Cleveland Clinic, Harvard, Duke and others - have started partnerships where they do the pre- and after-care at their facilities, either for consulting and other fees, or in exchange for part ownership of the foreign hospital.
  - Helps answer questions about pre- and post-op care, including complications

11

Facilitating medical travel

- Quality assurance
- Networks facilitated by open investment
- E-health
  - Helps ensure exchange of critical pre- and post-treatment data between sending and receiving providers.
  - Many countries lack a clear policy direction of the role of e-Health or a clear legal framework.

12

Issues in E-health

- Technical barriers at national and regional/global levels, such as noninteroperability of hardware, software and connectivity.
- Lack of accepted standard in e-Health application
- Harmonization of data privacy, use of 3rd party data storage (the cloud)

13

Facilitating medical travel

- Quality assurance
- Networks facilitated by open investment
- E-health
- Insurance
  - Employers seeking reduced health care costs
  - Insurers can offer lower cost premiums, but will it improve margins?
  - U.S. hospitals—significant loss of business?

14

Annex 14. Insurance Portability and Trade Facilitation: Benefits, Barriers, Solutions and Agenda for APEC Cooperation (Experience of Developing Economies as Receiving Countries)

Insurance Portability and Trade Facilitation

Benefits, Barriers, Solutions and Agenda for APEC Cooperation

Experience of Developing Economies as Receiving Countries

THAILAND

Asia-Pacific Economic Cooperation

International Insurance Experiences

Health Insurance with Global Coverage

- AIG
- Cigna
- CFE
- Daman
- Vanbreda
- Lawton
- Etc.

Travel Insurance (through assistance companies)

- International SOS
- AXA Assistance
- Mondial Assistance
- CEGA
- Euro-Center
- Etc.

2

Important Points on Insurance Trade

- Provider-Payer Business Agreement
- Health Care Standards and Codes
- Claims process
- Utilization Review

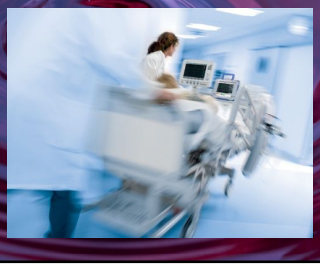
Provider-Payer Business Agreement

- Due Diligence
  - Service standards
  - Quality standards
    - Experiences (procedures performed)
    - Techniques/ method used
    - Success rates
    - Re-operation rates
    - Infection rates
  - Pricing
- Contract
  - Too safe or too risky
  - Place to settle legal disputes

4

Health Care Standards and Billing Codes

- Quality of Care
- Care Objectives
- DRG & CPT or Daily Rate



Claims process

- 24-hours service with decisions
- Language capabilities

Annex 14. Insurance Portability and Trade Facilitation: Benefits, Barriers, Solutions and Agenda for APEC Cooperation (Experience of Developing Economies as Receiving Countries)

Utilization Review

- Care objectives
- Constructive approach, unbiased

Possible Solutions

- Common litigation place or standards
- Common Standard of Care
- Common DRG system

Thank you for your attention

THAILAND

APEC Asia-Pacific Economic Cooperation

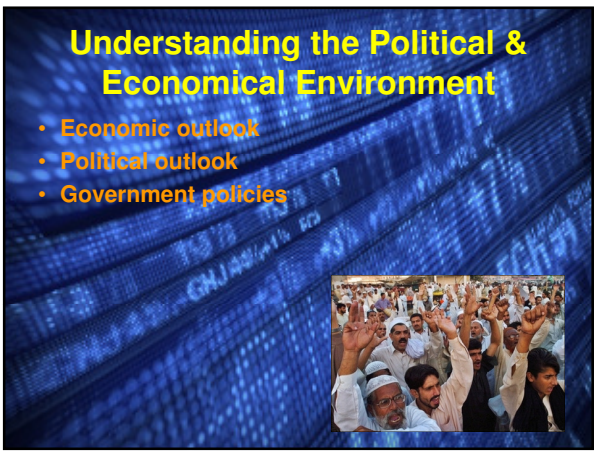

Experiences in Establishing
Overseas Presence
THAILAND
APEC
Asia-Pacific
Economic Cooperation


Dubai - plan


Dubai - 2009


Key Considerations for
Establishing Overseas Presence
• Understanding the Market
• Understanding the Political & Economical Environment
• Understanding the Business Environment


Understanding the Market
• Market Potential
• Consumers purchasing behavior
• Reaching consumers
• Competition
• Local culture


Understanding the Political &
Economical Environment
• Economic outlook
• Political outlook
• Government policies

Understanding the Business Environment

- Financing
- Labor
- Taxation
- Legal environment
- Bureaucratic obstacles
- Crime & corruption
- Infrastructure
- Foreign trade environment

Royal Angkor International Hospital

Royal Rattanak Hospital Phnom Penh

Key Concerns

- The right partner
- Taxation
- Income repatriation
- Medical licensing
- Local regulations and authorities
- Governmental support

Possible Solutions

- Accurate Business Information of APEC member countries e.g. website
- APEC-certified Business Organizations
- APEC Business Match-making events

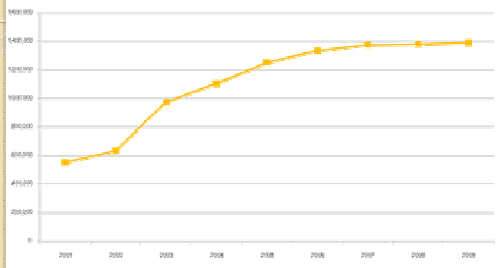

Thank you for your attention
THAILAND
APEC
Asia-Pacific
Economic Cooperation
13

Impact on Public Health and Policy Responses: A Case of Thailand

Songphan Singkaew, Ph.D.

1

Foreign Patients in Thailand



Number of Foreign Patients in Thailand, in 2001-2009

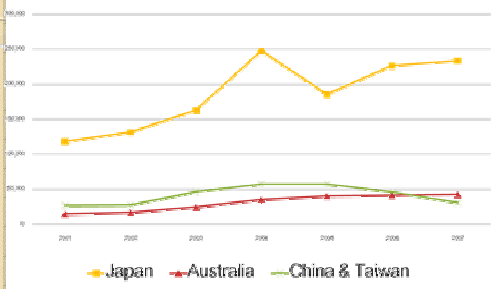
2

Composition of foreign patients

- In 2008, about 1.3 million foreign patients
- 58.6% are medical travelers and general travelers and
- 41.4% is the expatriates.

3

Foreign Patients



Country of Foreign Patients, Thailand in 2001-2007

4

Country of Foreign Patients

- Japan
- Germany
- US
- Myanmar
- UK
- UAE

5

Private Hospitals with Foreign Patients

- ❑Quality Physicians
- ❑Reasonable Price
- ❑International Standards
- ❑ Thai Hospitality

6

Private Hospitals

- Impacts
  - Higher Revenue
  - Broader Target
  - High Specialist

7

Public Hospitals

- Impacts
  - Less Revenue
  - Some patients might not have insurance (patients from bordering areas)

8

Problems

- ❑ Local Thais may have less access to health care services
- ❑ If doctors from government hospital move to private health institutions, the number of existing personnel in public hospital would decline.

9

Internal Migration of Doctors

- Private hospital demand for only specialist doctors who are credited with American Board or European Training , not GPs .
- Selection of private doctor is very strict, since it remains very high competitive in health industry.
- most of GPs usually serve mainly rural people, will hardly enter to private hospitals.

10

Distribution of medical doctors

Number and Percentage of Health Personnel (Medical Doctors, Dentists and Nurses) Classified by Regions, 2006-2007

Regio	No. of Medical Doctors				No. of dentists				No. of Register Nurses			
	2006	(%	200	(%)	2006	(%	200	(%	2006	(%	2007	(%
Bangkok	6,411	(30.5)	6,711	(29.6)	807	(19.3)	1,172	(25.2)	20,778	(20.5)	23,757	(22.5)
Central	5,113	(24	5,71	(25.	1,07	(25	1,1	(25	26,92	(26	27,68	(26
Northe	3,721	(17	4,02	(17.	967	(23	971	(20	21,15	(20	21,39	(20
North	3,547	(16	3,62	(16.	803	(19	800	(17	18,34	(18	18,62	(17
South	2,259	(10	2,57	(11.	536	(12	542	(11	13,94	(13	13,93	(13
Whole Country	21,051	(100)	22,651		4,187	(100)	4,653	(100)	101,143	(100)	105,398	(100)

Source : Number of health personnel classified by regions (2006-2007 adjusted from

11

Distribution of Doctor and Dentist

- The distribution of dentists slightly differs from doctors. They give services in Bangkok and Central region in a similar proportion.

12

Workload of Health Personnel

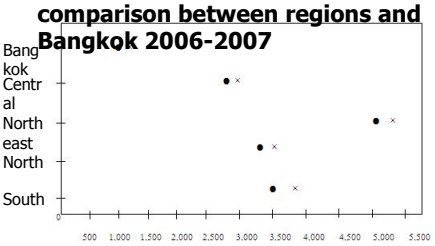
Proportion of population to doctor, 2006-2007

Regions	Proportion of population to doctor		Comparative indicies of workload of doctors between BKK and
	2006	2007	
Bangkok	1:889	1:852	-
Central	1:2,985	1:2,695	3.2
Northeast	1:5,754	1:5,309	6.2
North	1:3,352	1:3,277	3.8
South	1:3,807	1:3,365	4
Whole Country	1:2,985	1:2,783	

Source: Proportion of populations doctor classified by regions (2006-2007) are adjusted from 'Statistical Reports of Health Personnel'

13

Level of workload of doctors (classified by regions) comparison between regions and Bangkok 2006-2007



● : Population per doctor in 2007
× : Population per doctor in 2006

14

- If consider the level of complication of caring by types of illness, it may be better for those who practice in rural area. **Most cases in the District Hospitals usually not much complicated.**
- Though the workload among regions are imbalance, it is possible to say that newly GPs just started work may be appropriate to handle with the uncomplication of provision care services.

15

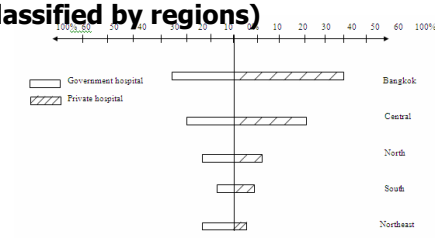
Number and growth rate of medical doctors in public and private hospitals (Classified by Regions) during 2006-2007

Regions	No. of doctors in Government hospital				Growth	No. of doctors in Private hospital				Growth rate
	2006	(%)	2007	(%)	(%)	2006	(%)	200	(%)	(%)
Bangkok Metropol	4,250	25.4	4,259	23.8	0.2	2,161	50.2	2,450	51.8	13.4
Central	3,893	23.3	4,40	24.6	13.0	1,220	28.3	1,31	27.8	7.7
Northea	3,494	20.9	3,78	21.1	7.6	227	5.3	243	5.1	7.0
North	3,134	18.7	3,20	17.9	2.3	413	9.6	416	8.8	0.7
South	1,971	11.4	2,26	12.6	14.8	288	6.6	309	6.5	7.3
Whole Country	16,742	100.0	17,917	100.0	7.0	4,303	100.0	4,732	100.0	9.97

Source: Number of medical doctors in public and private hospitals(2006-2007) are adjusted from 'Statistical Reports of Health Personnel'

16

Distribution of Proportion of doctors in Public and Private Hospital in 2007 (classified by regions)



Source: Number of doctors in public and private hospitals(2007) are adjusted from 'Statistical Reports of Health Personnel'

17

Distribution of medical doctors in Public and Private hospitals

- The trend of changing in distribution of doctors in private hospitals may be seen now. This dose not mean that there will be a fast movement of doctors from public to private hospitals. There is strictly regulations to prevent entry of specialists from public to private hospitals.

18

Number of medical specialists

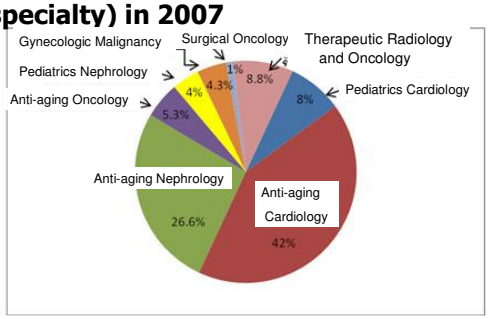
Number and percentage of specialists (whole

Area of	Number	%
Pediatrics	68	8.0
Anti-aging Medicine	336	42.0
Anti-aging	212	26.6
Anti-aging	42	5.3
Pediatrics	32	4.0
Gynecologic	34	4.3
Surgical Oncology	4	1.0
Therapeutic Radiology and	70	8.8
Total	798	-

Source: Number of specialists in 2007 are adjusted from

19

Proportion of medical specialist (by specialty) in 2007



20

- **For the changing trend of medical specialists, currently.**
  - If anyone holds some specialty in his/her profession, then there will be some value added extra to his/her return (or income).
  - Many professions, rather than general, also get the extra income due to their ability.

21

- Therefore, medical specialists have higher competency than GPs. The reason that most private hospitals need specialists because of their consumers/patients are those high-income groups-foreigners, or some Thai well-off families.
- The prediction here is : there will be a rapid movement of medical specialists group only (not GPs) since Thailand starts FTAs. The existing situation (though not having any FTAs), the movement already been conducted.
- The impact of loss of welfare may be seen.

22

Distribution of nurses

- RNs' pattern of distribution is slightly different from the medical doctors.
- In 2007, around 26.3% of nurses are in the Central region, more than in Bangkok (22.5%) , Northeast (20.3%), North(17.7%) and South(13.2%).

23

Two-tier System of Services

- GPs from government hospitals may get chance in practicing at private hospital , but very few are able to work as permanent.
- Patients of private hospital are foreigners and small number of the Thai well-off customers.
- Segment of foreign health care services is not the same as local

24

Standard and Pricing

- **Private Hospitals**
  - **International standard and higher price**
    - JCIA (Joint Commission International of American)
    - HA (Hospital Accreditation)
    - ISO (The International Organization for Standard)
- **Public Hospitals**
  - **National Standard and lower price**
    - HA (Hospital Accreditation)

25

Cross Border Diseases

26

Reported Case among Foreigners by Type and national, 2003

National	Migrant workers	Cross border and Foreigner	Total
	Cases	Cases	Cases
Myanmar	14,668	603	15,271
Laos	227	823	1,050
Cambodia	501	100	601
China	-	-	-
Malaysia	12	9	21
Vietnam	7	3	10
Other	3,105	1,147	4,252
Total	18,520	2,685	21,205

Source : Annual Epidemiological surveillance report 2003, Thailand

27

Reported Case among Foreigners by Type and National, 2008

National	Migrant worker	Cross border and Foreigner	Unspecified	Total
	Cases	Cases	Cases	Cases
Myanma	19,652	1,811	1,717	23,180
Cambodi	1,443	42	27	1,512
Laos	875	312	118	1,305
China	34	164	24	222
Malaysia	12	33	9	54
Vietnam	20	0	2	22
Other	1,812	2,418	2,872	7,102
Total	23,848	2,095	4,769	33,397

Source : Annual Epidemiological surveillance report 2008, Thailand

28

Cross Border Diseases (Thailand)

In 2003

- Acute diarrhea 7,165 cases
- Malaria 5,039 cases
- Pyrexia of unknown origin 2,392 cases
- Pneumonia 1,423 cases
- Hemorrhagic conjunctivitis 1,100 cases
- Dengue hemorrhagic fever 738 cases
- Food poisoning 631 cases

In 2008

- Acute diarrhea 12,382 cases
- Malaria 7,903 cases
- Pyrexia of unknown origin 3,141 cases
- Pneumonia 1,613 cases
- Dengue hemorrhagic fever 1,444 cases
- Sexually transmitted infection 189 cases
- Food poisoning 958 cases

29

Recommendations

- Branding
- Products and Services
- Target Penetration & Location
- Human Capital
- Quality and Standards
- Differentiate

30

Policy Responses

- Diversity Management
- Training / Workshop
- Language, Culture, Food,

31

Policy Responses

- Production
  - Investments
  - Quality Management
- Financial Supports
- Co-operation (Research, Business & Government)

32

Thank you for your attention.

33

Annex 17. Impact of Foreign Investments on Public Health: A Philippine example

APEC Seminar on Trade in Health, Cebu
February 9 - 11, 2010

An affiliate of Bumrungrad International

Asian Hospital and Medical Center

Impact of Foreign Investments on Public Health

Key Discussion Points

1. **Is there need for foreign investments on public health? A case study.**
2. **What are the advantages/disadvantages of foreign investments in the public health sector?**
3. **Potential obstacles to attract foreign investors.**

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Asian Hospital and Medical Center

Impact of Foreign Investments on Public Health

Is there need for foreign investments on public health?

- Knowledge base in healthcare management.
- Opportunities to improve the public health sector.
- Learn from mistakes made in the West.
- Reduce the "brain-drain" problem.

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Asian Hospital and Medical Center

Impact of Foreign Investments on Public Health

Case Study: Asian Hospital, Inc.

- Tertiary hospital in Alabang, South of Metro Manila area.
- A 217-bed, acute care hospital, operational since May 2002.
- Approx. 970 employees, 700 active physicians and some 250 outsourced staff.
- Known as a cardiac center due to Dr. Garcia, Founder.

An affiliate of Bumrungrad International

Asian Hospital and Medical Center

Impact of Foreign Investments on Public Health

Case Study: Asian Hospital, Inc.

- Financial restructuring in early 2005 due to losses incurred since starting hospital operations.
- Operational losses continued till and including financial year 2006.
- First operational profit in 2007 followed by years of improving operational profitability and cash flow.
- Started an expansion process in 2009.

An affiliate of Bumrungrad International

Asian Hospital and Medical Center

Impact of Foreign Investments on Public Health

Case Study: Asian Hospital, Inc.

- Key factors to achieve this result:
  - ✓ Fresh capital.
  - ✓ Foreign investor with management responsibility.
  - ✓ "Acquisition" of international expertise.
  - ✓ Implementation of a proper Hospital Inform-ation System (HIS).
  - ✓ Constant follow-up process.
  - ✓ Reduction of nurse turn-over.

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Annex 17. Impact of Foreign Investments on Public Health: A Philippine example

Asian Hospital and Medical Center

Impact of Foreign Investments on Public Health

What are the advantages/disadvantages of foreign investments in the public health sector?

- Acquire international expertise.
- Get access to management resources.
- Generate new/more job opportunities.
- Reduce the "brain-drain" problem (e.g. nurses).
- Know-how transfer.
- Improve the public health situation.

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Asian Hospital and Medical Center

Impact of Foreign Investments on Public Health

What are the advantages/disadvantages of foreign investments in the public health sector?

- Dependence on foreign know-how.
- Dependence on foreign capital.

APEC Seminar on Trade in Health – Cebu, February 9-11, 2010

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Asian Hospital and Medical Center

Impact of Foreign Investments on Public Health

Potential obstacles to attract foreign investors

- Red tape and corruption.
- Legal system.
- Capital flow (dividends, repatriation of capital).
- Cross-border borrowings.
- Taxes (income taxes, WHT, VAT, etc.).
- Tax audits (with unreasonable audit results).

APEC Seminar on Trade in Health – Cebu, February 9-11, 2010

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Annex 18. Experiences on Registration of Medical Tourism Ecozones in the Philippines

Experiences on Registration of Medical Tourism Ecozones in the Philippines

Atty. Genesis M. Adarlo
Consultant

"APEC Seminar on Trade in Health Services"
February 9-11, 2010
Venue: Shangri-La's Mactan Resoirt & Spa, Lapu-Lapu City, Cebu

1

What is the State policy involved?

- The State recognizes the indispensible role of the private sector, encourages private enterprise, and provides incentives to needed investments. (Sec. 20, Art II, 1987 Constitution)

2

What is Medical Tourism in the Phil. context?

- It is travel to the Philippines for the purpose of availing quality but affordable healthcare services or treatment of illnesses and health problems in order to maintain one's health and well-being.

3

What is the legal basis?

- Executive Order No. 372, series of 2004 – created the Public-Private Sector Task Force for the Development of Globally Competitive Philippine Service Industries
- Executive Order No. 571, series of 2006 – created a Public-Private Sector Task Force on Philippine Competitiveness
- Board of Investments (BOI) included the health and wellness products and services as preferred activities in the 2005 Investment Priorities Plan (IPP)
- Philippine Economic Zone Authority (PEZA) issued Board Resolution No. 06-512 approving the Guidelines for the Registration of Medical Tourism Special Economic Zones (Medical Tourism Parks/Centers) and Medical Tourism Enterprises under Republic Act No. 7916, as amended

4

What are the health and wellness services in the 2005 Investment Priorities Plan (IPP)?

- Hospital/Medical Services
- Ambulatory Surgical Services
- Dental Services
- Other Human Health and Wellness Services including Rehabilitation and Recuperation Services
- Retirement Village and Other Related Services
- Development of Medical Zones

5

What is R.A. No. 7916, as amended by R.A. No. 8748?

- An Act providing for the legal framework and mechanisms for the creation, operation, administration, and coordination of special economic zones in the Philippines, creating for this purpose, the Philippine Economic Zone Authority (PEZA), and for other purposes

- The Special Economic Zone Act of 1995

6

Annex 18. Experiences on Registration of Medical Tourism Ecozones in the Philippines

What is a Special Economic Zone?

- Special Economic Zone (SEZ) – a selected area that is highly developed or which have the potential to be developed into agro-industrial, industrial tourist/recreational, commercial, banking, investment and financial centers. An ECOZONE may contain any or all of the following: Industrial Estates (IEs), Export Processing Zones (EPZs), Free Trade Zones, and Tourist/Recreational Centers.

7

What are the pertinent terms involved?

- Medical Tourism Economic Zone
- Medical Tourism Park
- Medical Tourism Center
- Medical Tourism Enterprise

8

What is a Medical Tourism Economic Zone?

- A selected area that is highly developed or which has the potential to be developed into a Medical Tourism Park/Center
- The location is fixed/delimited and declared by Presidential Proclamation

9

What is a Medical Tourism Park?

- An area which has been developed into a complex capable of providing medical infrastructures and other support facilities in compliance with DOH and DOT requirements
- Includes medical accommodations, wellness centers, spa, health farms, sports and recreational facilities, and rehabilitation facilities required by Medical Tourism Enterprises, as well as amenities required by foreign patients including professionals and workers involved in medical tourism activities
- Shall have a minimum lot area of one (1) hectare

10

What is a Medical Tourism Center?

- Either a medical hospital or a stand-alone building attached to a hospital that hosts specialized medical clinics and other specialized medical related activities in compliance with DOH requirements
- A stand-alone building attached to a hospital shall have a minimum floor area of 5,000 sqm. for Metro Manila and Cebu City, and 2,000 sqm. minimum floor area for the provinces and cities outside of Manila and Cebu City
- Has infrastructures and other support facilities required by Medical Tourism Enterprises
- May also provide amenities required by foreign patients including professionals and workers involved in medical tourism activities

11

What is a Medical Tourism Enterprise?

- A corporation or other form of business entity which has been endorsed by the DOH and registered with the PEZA to engage in the practice of medical health services with foreign patients as primary clientele

12

Annex 18. Experiences on Registration of Medical Tourism Ecozones in the Philippines

What are the types of activities of a Medical Tourism Enterprise?

- Medical Services – Allergology; Clinical Immunology; Rheumatology; Cardiology; Clinical Genetics; Clinical Nutrition; Emergency Care; Endocrinology and Metabolism; Gastroenterology; Infectious and Tropical Diseases; Nephrology; Neurology; Psychiatry; Radiology , Radiotherapy, and Interventional Radiology; Hematology; Oncology or Cancer Medicine; Pulmonology; Critical Care; Geriatric Care; Lifestyle Health Service; Dermatology; Pain management; Complementary and Integrative Medicine
- Surgical Services – Neurosurgery; Cardiothoracic surgery; Gastroenterology surgery; ENT; Ophthalmology; Urology; Transplant surgery; Orthopedics; Cosmetic, Plastic, and Reconstructive Surgery

What are the types of activities of a Medical Tourism Enterprise?

- Obstetric and Gynecologic Services
- Pediatric, Perinatology and Neonatology Services
- Dental and Orthodontic Services
- Optometry and Orthoptic Services
- Spa and Health Farms
- Drug Addiction Treatment and Rehabilitation Services

What are the fiscal incentives of a Medical Tourism Enterprise?

- 4 years Income Tax Holiday (ITH) on income solely derived from servicing foreign patients
- Upon the expiry of the ITH period, payment of 5% Gross Income Tax on income solely derived from servicing foreign patients, in lieu of all national and local taxes
- Tax and duty-free importation of medical equipment, including spare parts and equipment supplies, required for the technical viability and operation of the registered activity(ies) of the enterprise

What are the non-fiscal incentives of a Medical Tourism Enterprise?

- Employment of foreign nationals
- Special Investor's Resident Visa (47A 2)

What is the current status of Medical Tourism Ecozones in the Phils.?

- One (1) Registered Medical Tourism Park – located in Sto. Tomas, Batangas
- One (1) Registered Medical Tourism Center – located in Bonifacio Global City, Taguig City

What is the participation of DOH?

- BOI requires DOH endorsement re: applications for BOI registration of healthcare projects
- DOH issued A.O. No. 6, s. 1998 and A.O. No. 81, s. 2000

Annex 18. Experiences on Registration of Medical Tourism Ecozones in the Philippines

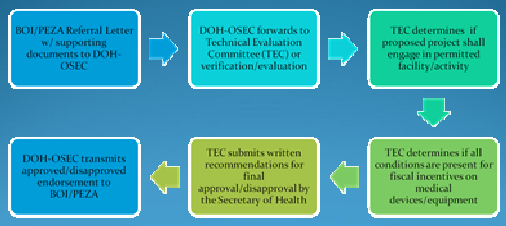
What is the participation of DOH?

- PEZA requires DOH endorsement of applications for PEZA registration of Medical Tourism Special Economic Zones (Medical Tourism Parks/Centers) and Medical Tourism Enterprises
- DOH issued A.O. No. 2009-0015 - Interim Policies and Guidelines for Endorsement of Applications for Registration of Global Healthcare or Medical Tourism Projects under the BOI and PEZA

What are the interim policies provided in A.O. No. 2009-0015?

- Medical tourism projects must be part of the Philippines' integrated and comprehensive approach to health development which endeavors to make essential goods, health and other social services available to all the people at affordable cost.
- Registration of medical tourism projects shall always take into account the impact on the Philippines' public healthcare system and the concomitant risks.
- Applicants for registration of medical tourism projects must provide programs, mechanisms, or strategies which share the benefits of medical tourism with the public healthcare system through public service, such as community-building projects, establishment of service wards and facilities, scholarship programs, training agreements between public hospitals and private hospitals.

How do you obtain DOH endorsement under A.O. No. 2009-0015?



What are the conditions to obtain fiscal incentives on medical devices/equipment?

- The medical devices or medical equipment must be brand new and up-to-date.
- Procurement and use of the said medical devices and equipment must have complied with all the necessary health regulatory documents and permits from the country of origin and from the BHDT.
- The medical devices or medical equipment shall be solely used for therapeutic and/or diagnostic purposes limited to the medical tourism services.

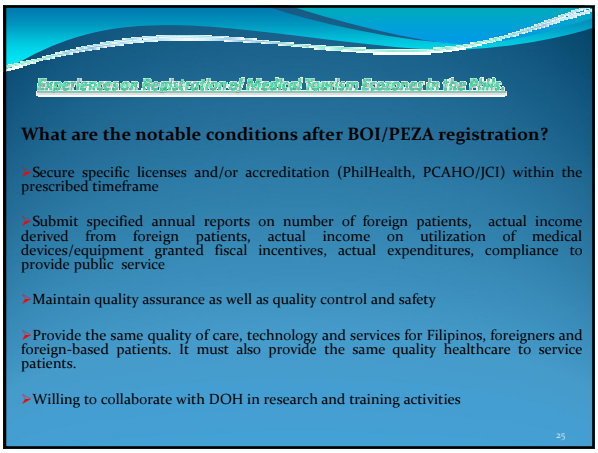
What are the conditions to obtain fiscal incentives on medical devices/equipment?

- The medical devices or medical equipment shall have a minimum freight-on-board (FOB) unit cost of US$100,000.00. The minimum FOB cost shall be determined and periodically reviewed every two (2) years by the BHDT based on the prevailing cost of medical devices or equipment.
- The medical devices or medical equipment must be fixed to or owned by the proposed facility or activity and cannot be considered as personal property.
- The medical devices or medical equipment must not be locally-manufactured.

What are the conditions to obtain fiscal incentives on medical devices/equipment?

- The proposed healthcare or medical tourism project must use health care technology that has been scientifically proven effective, safe and evidence-based.
- The proposed facility or activity must provide the same quality of care, technology and services for Filipinos, foreigners and foreign-based patients. It must also provide the same quality healthcare to service patients.
- Facilities must submit a detailed program, mechanism, or strategy which provides public service, such as, but not limited to, community-building projects; establishment of service beds numbering at least 10% of the authorized total bed capacity; scholarship programs; and training agreements between public hospitals and private hospitals.

Annex 18. Experiences on Registration of Medical Tourism Ecozones in the Philippines



TRADE IN HEALTH SERVICES STATISTICS

Cynthia C. Lazo
Director
Sports and Wellness Tourism
Department of Tourism
Philippines

UNIQUENESS OF THE PHILIPPINE HEALTH & WELLNESS

Healthcare And Tourism, A Winning Combination In The Philippines

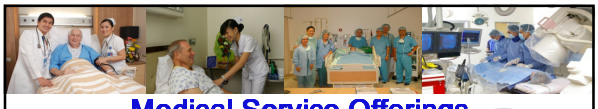
- ✓ *Competitive medical services and world-class facilities*
- ✓ *Ideal travel destination*

Our Advantages

Highly qualified compassionate, culture-sensitive, resourceful, intuitive healthcare professionals

Relatively large pool of trainable personnel
Very good price to quality ratio in medical care
The required linkages – tour operations, hospitals, tourism facilities, telecommunications, IT providers, educational institutions, insurance firms etc – to support health tourism exist

Joint Foreign Chambers in the Philippines have identified, among six others, tourism, including medical travel, as the winner sector for rapid growth.



Medical Service Offerings

- ✓ *Comprehensive Medical Evaluation and Examination*
- ✓ *(Executive Check-Ups)*
- ✓ *Diagnostic and Laboratory Technologies*
- ✓ *Aesthetic, Dermatologic, Plastic & Reconstructive Surgery*
- ✓ *Multi-Disciplinary Weight Management Care*
- ✓ *Dental / Oral and Maxillofacial Surgery*
- ✓ *Eye Care and Sight Restoration*
- ✓ *Cancer Care and Treatment / Stem Cell Therapy*
- ✓ *Cardiovascular*
- ✓ *Joint Replacement (Hip & Knee) and Resurfacing*
- ✓ *Obstetrics-Gynecology*
- ✓ *Rehabilitation Medicine*

Wellness Service Offerings

- ✓ *Philippine Hilot*
- ✓ *Complementary, Integrative and Traditional Medicine*
- ✓ *Day Spas*
- ✓ *Medical Spas*
- ✓ *Resort and Hotel Spas*
- ✓ *Hospital Spas*

Over-all Role and Mandate Of Department Of Tourism

"Delivery on a promise"

Provide a seamless compelling experience for visitors with the resulting outcome

- *Complete visitor satisfaction*
- *Passenger safety*
- *Cultural awareness*
- *Return visits*
- *Enhance brand value*
- *Create niche traveler experience*
- *Record and update data*

ENABLING LAWS/PRONOUNCEMENTS

A. New National Tourism Act Republic Act No. 9593

B. EXECUTIVE ORDER NO.372 Issued October 18, 2005
Health and Wellness
The EO created a public –private partnership task force to provide an enabling environment for the competitiveness of the industry to serve the global markets.

C. National Health and Wellness Month -Presidential Proclamation 1280 ***"Month of October as National Health and Wellness Tourism month"***

Health and Wellness Alliance of the Philippines (HEAL-Philippines)
("The umbrella organization of Health and Wellness and Retirement Stakeholder in the Philippines")

DOH, DOT, DTI, DFA and the PPP Task Force
ADVISORY BOARD

Medical and Surgical Services Group	Rehabilitation services and retirement group	Healthy Lifestyle Promotion and Disease Prevention Group	Trade, Tourism, Investment and Promotion Group
• Tertiary / hospital-based Medical Care Services including immediate rehabilitation (post-CABG, post-stroke, etc.) • Ambulatory Surgical services • Dental Services	• Long-term care services (hospice, palliative, etc.) • Elderly care • Long term rehabilitation services (drug addiction) • Retirement facilities	• Wellness and Spa Services • Sports and personal fitness services • Nutritional clinics and diet / weight management centers • Complementary and alternative medicine	• Medical integrators / concierges • Travel agencies • Tour operators • Hotel associations • Medical butlers • DFA embassies, consulates, FTSC / PTICs, DOT Tourism attaches • Transportation / aviation groups

POSITIONING THE PHILIPPINES AS THE HEART OF ASIA

Promote the Philippines as:

✓ *the destination of choice for healthcare and total wellness with its competent professionals and caring nature and global technologies*

STRATEGIC OVERVIEW

- *National brand*
- *Niche markets*
- *Value for money services*
- *Accreditation*
- *Networking*
- *Quality of standards*
- *Quality of care*
- *Leadership - patient path*
- *Institutionalizing policy*
- *Advocacy and Responsibility*

Philippine Health and Wellness Industry Performance

TOOLS USED TO MEASURE INDUSTRY PERFORMANCE

- *Embarkation/Debarkation Cards (E/D Cards)*
  - *Captures the number of visitors that arrived at the ports of entry with medical tourism as the main motivation*
  - *Gathered through the Department of Tourism in partnership with the Bureau of Immigration*

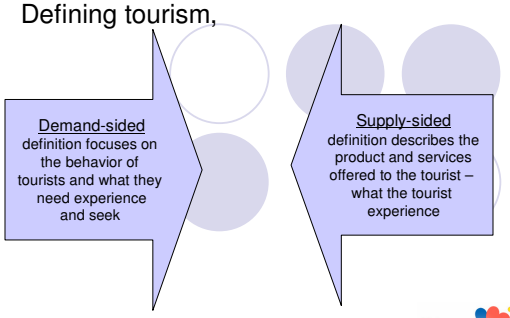
Philippine Health and Wellness Industry Performance

- *Taylor Nelson Sofres (TNS) Survey (2009)*
  - *Captures data covering nine (9) institutions involved in medical tourism accredited by this department*
  - *Administered by the Philippine Department of Tourism through a survey questionnaire*
- *Survey of Tourism Establishments in the Philippines (STEP)*
  - *Captures data on capacities among the different hotels and similar establishments*
  - *administered by the Philippine Department of Tourism with the support of the Philippine Department of Health*

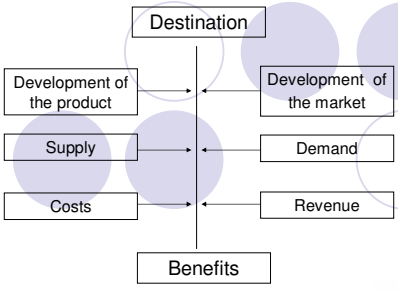
2009 Survey of Tourism Establishments in the Philippines (STEP)

Backgrounder:

Defining tourism,



Tourism Supply and Demand Relationship



SUPPLY FRAMEWORK

Accommodation *Type of accommodation*
Restaurants, Cafes and Canteens *Type of facility*
Transport *Type of Transport company*
Recreational, Cultural, Sporting Activities & Other Attractions *Type of facility*
Other Services *Type of service (Travel Agent/Tour Operator/Guides/National Tourist Officers)*
Tourism Price Indices *For accommodation establishments and other tourism supply*

DEMAND FRAMEWORK

Tourist Arrivals
Month of the Year; Country of Residence; Purpose of Visit; Mode of Transport: Port of Entry; Country of Residence by Purpose of Visit; Country of Residence by Mode of Transport;
Country of Residence by Sex and Age; Type of Accommodation

Same-day Visitors
Day trippers; cruise ship visitors

Average length of stay
Country of residence; Purpose of visit; Type of Accommodation

Bed Nights, Room and Bed Occupancy
Type of Accommodation; Grade of Accommodation; Location of accommodation Site of Accommodation; Month of Year

Tourist Expenditure
Country of Residence; Type of accommodation

Qualitative Tourist Data
Factors Influencing decision to travel; Main source of information
Activities engaged in during the visit; trip planning characteristics; Trip ratings

Backgrounder:

- **Tourism Supply Statistics**
  - Needed to assess capacity of destination to service visitors (e.g. accommodation)
  - Needed to assess tourism-Related and tourism-oriented Enterprises' economic impact In the destination (e.g. employment related and revenue generation)
  - Needed for investment planning and to evaluate implementation of programs

Department of Tourism Supply Statistics
- not quite reflective of the real situation for specific local destinations

WHY?

DOT can only collect data related to tourism capacity based on accreditation and destination-specific surveys

Backgrounder:

Survey of Tourism Establishments In the Philippines (STEP)

The survey will address the gaps and the limited data on tourism supply statistics. It will also be a valuable input in the compilation of the Philippine Tourism Satellite Account and in the formulation of national and local tourism plans.

Project Proponents:

Department of Tourism and the National Statistical Office with the support of the Department of Health

-The survey will be conducted in 2010 using the budget of the National Statistical Office

SURVEY OBJECTIVES:

- To provide data on supply and capacity of
- tourism establishments in the Philippines
- To provide an inventory of facilities and services available in the regions
- To gather data on employment in tourism establishments
- To gather data on revenues generated by tourism establishments
- To provide data on investments in tourism and tourism-related establishments

Tourism Establishments Included in the Survey:

- Accommodation
- Transportation
- Restaurant
- Travel Agency
- Tour Operators
- Tertiary Hospitals for Medical Tourism
- Ambulatory Clinics
- Spa
- ESL (English as Second Language)institutions

List of Common Data Variables Needed

- Number of Establishments
- Type
- Accreditation Status
- Number of Employees by Sex, Nationality, and Appointment
- Plan of Future Expansion and Estimated Cost
- Revenue Generated

Additional Data Variables Needed Specific to Data Sources:

- Accommodation
  - Number of Rooms
  - Estimated Number of Rooms for Expansion
- Transportation
  - Seating Capacity
  - Estimated Number of Fleets and Seats for Expansion
- Restaurant
  - Seating Capacity
  - Estimated Number of Seats for Expansion
- Tertiary Hospitals for Medical Tourism/Ambulatory Clinics
  - Number of Rooms

Required Reports (1)

- Number and Percentage Share of Establishments by Type and Classification
- Number and Percentage Share of Rooms by Type of Establishments
- Number and Percentage Share of Seats by Type of Transport Equipment
- Number and Percentage Share of DOT-accredited establishments by Type
- Number of Employees by Type of Establishments
- Number of Employees by Type of Establishments and by Sex

Required Reports (2)

- Number of Employees by Type of Establishment and by Nationality
- Number of Employees by Type of Establishments and by Type of Appointment
- Number of Establishments by Type with Future Expansion/Renovation
- Number of Establishments by Type with Future Expansion/Renovation and Number of Rooms/Number of Seats
- Estimated Cost of Expansion by Type of Establishment
- Revenue Generated by Type of Establishment

Report Disaggregation

- By Region, Province, City/Municipality
- By Specific Destination

Mabuhay!


TARGET MARKETS
▪Near Shore – Guam, Palau, Micronesia, Northern Marianas (Saipan)
▪Australia
▪Japan
▪US
▪Canada
▪Europe – UK, Germany, France, Benelux (Belgium, The Netherlands, Luxembourg)
▪Middle East – Gulf States including Bahrain, Iran, Iraq, Kuwait, Muscat, Oman, Qatar, Kingdom of Saudi Arabia, United Arab Emirates
Philippines
The Heart of Asia

Measuring Quality of Health Care through Accreditation of Health Providers and Facilities

APEC Seminar on Trade in Health Services
9-11 February 2010
Cebu City

Shirley B. Domingo MD
OIC Senior Vice President
Health Finance Policy Sector
Philippine Health Insurance Corporation

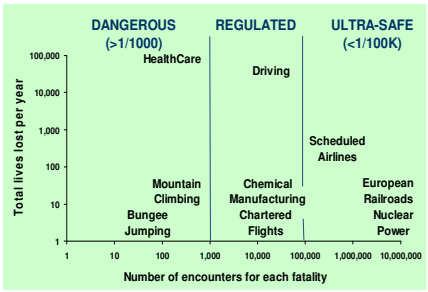
1

- 'Health Systems need protection from possible adverse effects of globalization treaties… There is danger that important global trade treaties will create a competitive environment with a focus on clinical sophistication at the expense of affordable, cost effective, public health investments.'

Eastern Mediterranean Regional Office
World Health Organization

2

The Quality Problem is Large



U.S. Healthcare Is Hazardous:

- 7% of patients suffer a medication error
- *Every* patient admitted to an ICU suffers adverse event
- 44,000- 98,000 deaths
- $50 billion in total costs

Back

Source: Leape, Lucian

3

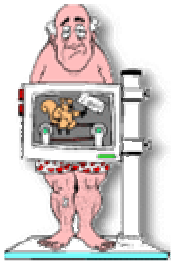
Quality Dimensions

- Safety
- Effectiveness

4

Quality Dimensions

- Efficiency
- Appropriateness



5

Quality Dimensions

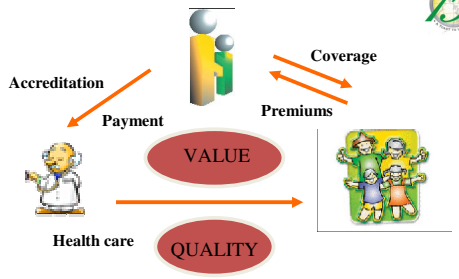
- Accessibility
- Consumer participation

6

7

Accreditation – a self assessment and external peer assessment process used by health care organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve

8



Relationship bet. Phil Health, the health care providers and its members.

9

PhilHealth Benchbook

- Contains Philhealth's standards of quality
- Continuous quality improvement
- Self-assessment
- Demonstration of achievements and outcomes

10

Benchbook Indicators

- Developed through several consultative meetings
- Stakeholders suggested indicators for each standard and criteria
- Stakeholders agreed to set some indicators as CORE indicators
- Survey tool which contains CORE indicators were pilot tested in 2008
- Revision of some indicators and listing/delisting of CORE indicators

11

Rationale for Benchbook Standards

PhilHealth perspective:

- Legal mandate
- Existing accreditation standards do not promote a quality improvement culture among hospitals
- Concern with variation with health care practice, outcomes and costs
- Need to influence provider behavior to increase the likelihood of better outcomes at affordable costs- member protection
- Rising demand and costs, limited health expenditures and resources--efficiency

12

Rationale for Benchbook Standards

Provider perspective:

- Tougher competition
- Frequent medical errors- safety issues → lawsuits!
- Rising demand and costs, limited health expenditures/resources
- Concern with variation with health care practice, outcomes and costs
- Patient satisfaction

Next

13

Figure 7. PhilHealth Quality Standards for Health Care

Performance Area	Standards n=78	Criteria n=141	Indicators n=239	Core Indicators n=51
Patient Rights	6	14	19	1
Patient Care	30	75	112	15
Leadership & Mgt	6	4	14	3
HR Mgt	8	19	27	2
Info Mgt	5	11	15	3
Safe Practice	16	16	40	25
Improving Performance	7	2	12	2

15

Patient Care

Goals:
- Comprehensive assessment of every patient enables the planning and delivery of patient care
- Care is delivered in a timely, safe and appropriate manner
- Upon discharge, care is coordinated with providers in the community

Standards:
- Professionals perform coordinated patient assessment
- Care plan is consistent with scientific evidence

Criteria:
- Previously obtained information is reviewed at every stage of the assessment to guide future assessments
- Expert judgment, practice standards and patients' values are considered in developing care plans.

Indicators:
- Percentage of charts with progress notes by doctors
- Proof that practice standards and when necessary, expert judgment and patient's values are considered in the care plan

16

Patient Rights and Organizational Ethics

Goal:
- To respect patients' rights and ethically relate with patients

Standard
- Follows procedures for confidentiality, privacy and security

Criteria:
- Informed consent
- Policies on confidentiality and privacy

Indicators:
- Percentage of patient charts with signed consent
- Proof of hospital staff awareness and compliance with policy in addressing patients' needs for confidentiality and privacy

17

Leadership and Management

Goals:
- The organization is effectively and efficiently governed and managed according to its values and goals to ensure that care produces the desired health outcomes, and is responsive to patients' and community needs

Standards:
- The organization develops and implements policies and procedures which cover the major services and aspects of operations

Criteria:
- The organization's by laws, policies and procedures support care delivery and are consistent with its goals, statutory requirements and its community responsibilities

Indicators:
- Presence of written by-laws, policies and procedures, which are consistent with goals, statutory requirements, accepted standards and community and regional responsibilities

18

Annex 20. Measuring Quality in Health Care thru Accreditation of Health Providers and Facilities

Human Resource Management

Goals:
- The organization provides the right number and mix of competent staff to meet the needs of its internal and external customers and achieve its goals

Standards:
- Appropriate skill mix and staff numbers are available

Criteria:
- Staff numbers and skill mix are based on actual clinical needs

Indicators:
- Presence of policies and procedures on hiring of staff

19

Information Management

Goals:
- Integrity, safety, access and security of records are maintained and statutory requirements are met (Records mangement)

Standards:
- Relevant, accurate quantitative and qualitative data are collected and used in efficient patient care
- Clinical records are accessible, kept confidential and safe, and comply with all relevant statutory requirements and codes of practice.

Criteria:
- Organization defines procedures to improve accuracy, completeness and reliability of relevant data

Indicators:
- Presence of policies and procedures to monitor and improve the accuracy, completeness and reliability of relevant qualitative and quantitative data relating to its operations

20

Improving Performance

Goals:
- The organization continuously and systematically improves its performance by invariably doing the right thing the right way the first time and meeting the needs of its internal and external clients

Standards:
- New processes of care are designed based on scientific evidence
- Better care service as a result of continuous quality improvement activities

Criteria:
- Philhealth CPGs for the top 10 admissions are disseminated and monitored

Indicators:
- Proof of dissemination of PhilHealth-adopted CPGs for the 10 conditions (if CPG is applicable in the hospital)
- Presence of patient satisfaction survey

21

Safe Practice and Environment

Goals:
- Risks of acquisition and transmission of infections among patients, employees, physicians and other personnel, visitors and trainees are identified and reduced

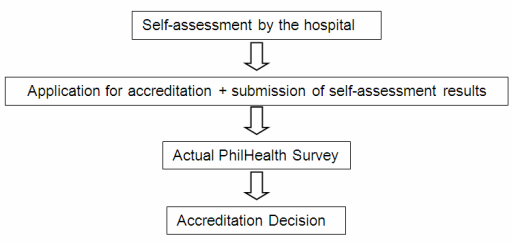
Standards:
- Infection Control Program ensures prevention of infection in all services

Criteria:
- Safety from hazardous materials and biological wastes,fire safety, emergency and disaster preparedness are implemented
- The organization takes steps to prevent and control outbreaks of nosocomial infections

Indicators:
- Proof of the implementation of the policies and procedures for safe and efficient use of medical equipment
- Presence of a coordinated system-wide procedure for case containment of nosocomial infections

22

Benchbook Self-Assessment Process & Accreditation



23

Warranties of Accreditation, Institutions

- they recognize the authority of PhilHealth to any inspection or investigation
- accept the program of quality assurance, payment mechanism and utilization review of the NHIP
- shall guarantee safe, adequate, and standard medical care
- its personnel shall adhere to a strict Code of Ethics
- they agree to adhere to practice guidelines or protocols, peer reviews and other QA activities

24

Recognition

25

25

Number of Health Care Providers
(as of December 31 2009)

Health Care Professionals	
Physicians	22,951
Dentists	195
Midwives	355
Health Care Institutions	
Hospitals	1,654
Ambulatory Surgical Clinics	36
Free Standing Dialysis Clinics	39
OPB Providers	1,301
Maternity Care Clinics	627
Anti –– TB/DOTS Clinics	710

26

Maraming Salamat Po!

27

Definition of Quality

- **Refers to the degree to which health care increases the likelihood of desired health outcomes, and is consistent with current professional knowledge**

- Lohr, Institute of Medicine

28

PhilHealth's QAP Activities

- Accreditation
- Feedback Mechanism
- Performance Monitoring
  - Utilization Review
  - Outcomes Assessment
- Implement QA standards in the medical evaluation of claim applications for reimbursement
- Program Review/Formulation of policies

29

Legal Mandate

- R.A. 7875 (as amended by R.A. 9241) Sec. 37. Quality Assurance

  …health care providers shall take part in programs of quality assurance, utilization review, and technology assessment …

- IRR Rule IX, PhilHealth shall…
  - Implement a QAP applicable to all HCPs for the delivery of health services nationwide
  - Shall ensure that the health services rendered to members by accredited HCPs are of the quality necessary to achieve the desired health outcomes and member satisfaction

30

1

ASEAN Mutual Recognition Arrangements:

THE PHILIPPINE EXPERIENCE

Presented by:
Kenneth G. Ronquillo, MD
Director
Health Human Resource Development Bureau
Department of Health
Philippines

2

ASEAN

The Governments of Brunei Darussalam, the Kingdom of Cambodia, the Republic of Indonesia, Lao People's Democratic Republic, Malaysia, the Union of Myanmar, the Republic of the Philippines, the Republic of Singapore, the Kingdom of Thailand, and the Socialist Republic of Viet Nam, Member States of the Association of South East Asian Nations.

3

ASEAN FRAMEWORK AGREEMENT ON SERVICES

- Enhance cooperation in services
- Eliminate restrictions to trade in services
- Liberalize trade in services

4

ASEAN VISION 2020

- Stable, prosperous and highly competitive ASEAN economic region
  - Free flow of goods, services and investments
  - Equitable economic development and reduced poverty and socio-economic disparities
  - Enhanced political, economic and social stability

5

Article V AFAS

- ASEAN Member States may recognize the education or experience obtained, requirements met, or licenses or certifications granted in another ASEAN Member State, for the purpose of licensing or certification of service suppliers

6

9th ASEAN Summit

- Bali Concord II:
  calling for the adoption of MUTUAL RECOGNITION ARRANGEMENTS for qualifications in major professional services by 2008

7

Mutual Recognition Arrangements

- Goal:
  - Facilitate trade in services by mutual recognition of authorization, licensing, or certification of professional service suppliers
- Objectives:
  - Facilitate mobility of health professionals within the ASEAN
  - Exchange information and enhance cooperation in respect of mutual recognition of health professionals
  - Promote adoption of best practices on standards and qualifications
  - Provide opportunities for capacity building and training of health professionals

8

MRAs under the Healthcare Sector Services

- Medical Practice
  - Signed on 26 February 2009
- Dental Practice
  - Signed 26 February 2009
- Nursing Services
  - Signed 08 December 2006

9

PHILIPPINE PARTICIPATION

- Crafting of the MRAs
  - MRA on Nursing Practice: 2003 – 2006
  - MRAs on Medical and Dental Practice: 2007 – 2008
- Participation in the harmonization process
- Advocacy of the MRAs to health professional country leaders and the private sector

10

PHILIPPINE PARTICIPATION

- Signing of the MRAs
- Ratification of the MRAs
- Submission to the ASEAN Secretariat of country specific
  - Competency requirements
  - Qualification for job placements
  - Accreditation of training institutions
  - Existing laws for the practice of the profession

11

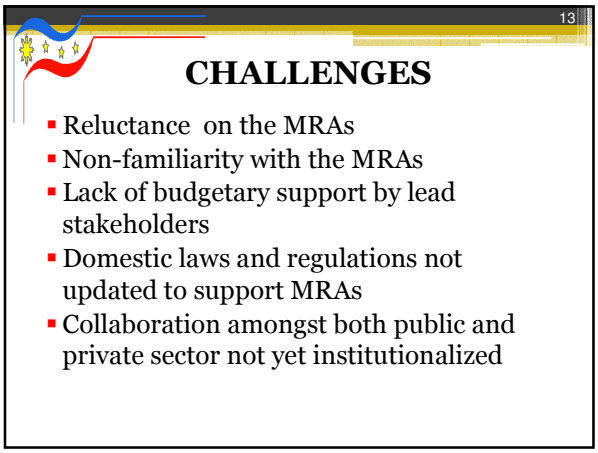
2010 ACTIVITIES

- Development of WEBSITE for the ASEAN Healthcare Sector Services Working Group
  - ASEAN Nurse
  - ASEAN Physician
  - ASEAN Dentist
- Organization of the required structure for implementation of the MRAs
  - ASEAN Joint Coordinating Committees
  - Philippine Regulatory Authorities

12

2010 ACTIVITIES

- Identification of areas of practice where flow of ASEAN professionals could happen
- Aligning the ongoing Residency Training of ASEAN Medical graduates in the Philippines with provisions in the MRA (e.g. Indonesia)
- Monitoring and reporting of inflow of ASEAN Professionals under the MRA framework


13
CHALLENGES
Reluctance on the MRAs
Non-familiarity with the MRAs
Lack of budgetary support by lead stakeholders
Domestic laws and regulations not updated to support MRAs
Collaboration amongst both public and private sector not yet institutionalized


14
ASEAN Mutual Recognition Arrangements:
THE PHILIPPINE EXPERIENCE
THANK YOU
Kenneth G. Ronquillo, MD
kronquillo@co.doh.gov.ph
ken2000_hhrdb@yahoo.com

Annex 22. Liberalization of Professional Practice: Moving Forward Across Borders to Improve Access, Service Delivery, Population Health Outcomes

APEC SEMINAR ON TRADE IN HEALTH SERVICES

Liberalization of Professional Practice—Moving Forward Across Borders to Improve Access, Service Delivery, Population Health Outcomes

10th February 2010
Cebu, Philippines

1

Session Overview

- Objectives of trade liberalization and MRAs
- Identified common issues, options for further action
- Protection of the public and "competence" of health professionals—qualifications to enter into practice, linked to technical standards and licensing requirements
  - Validating competence; scopes of practice; regulatory matters
- Call for *Radical Transformation*

2

Trade Liberalization—Promoting Global Trade in Services

- Health services facilitated by movement of health workers
- Health services, under GATS: "Trade" in 4 modes:
  - Cross-border services supply from country to country, via IT
  - Consumption abroad of services by patients traveling abroad for treatment
  - Commercial investments, establishment of subsidiaries in other countries
  - Health professional emigration between countries
- MRAs—facilitate movement of professionals and the processes of international recognition

3

Trade Liberalization

Trade liberalization has both positive and negative potential effects:

- New employment opportunities may open up
- Mitigate unemployment
- Economic growth, stability via employment, remittances
- Can also lead to higher costs of health services and supplies, lower quality of services, health personnel shortages in due to increased migration and/or urban concentration
- Access to services by remote or vulnerable populations may be negatively impacted

4

Trade Liberalization

Does trade liberalization cause changes in health outcomes or vice versa??

- Protect positive gains/reduce negative impacts
  - Governance—Monitor policy objectives to ensure national health policy aims are not sacrificed by for-profit commercial enterprises
  - New employment opportunities ……However, in some countries, private sector expansion furthers rural to urban migration [problematic without protection for migrant workers]

5

Trade Liberalization

- Protect positive gains/reduce negative impacts
  - Potential risks for increased gender-based violence
  - Employment opportunities but health risks due to hazardous work environments
  - Careful monitoring of negotiations, agreements and their implementation

[ICRW. *Trade Liberalization and Women's Reproductive Health: Linkages and Pathways.* 2009]

6

Globalization, Emerging Threats and Health Systems

8

Are patients satisfied or dissatisfied with health services, given the many advances in medical science, health professions, technology?

9

Why are patients dissatisfied?

- "Disease" rather than "illness" or person-focused care—supply driven, rather than customer driven health services
- Limited patient voice in treatment decisions
- Lack of a conducive atmosphere for expression of anxieties, distress
- Mechanical care for many patients, those with terminal illnesses
- Lack of privacy, protection of dignity; environments not conducive to recovery
- Costs too high or unaffordable

10

Recent review findings from interviews with people with chronic conditions

People want:

- More time with their doctors and nurse
- Better explanations about their conditions
- Less unsettling failures in communication
- Assistance with accessing and coordinating services
- Assistance with the costs of health care
- Recognition of their life and culture
- Acknowledgement of links between mental and physical health

11

- **Only 55% of patients diagnosed and treated adequately** (United States of America, *Report of Institute of Medicine*, 1999)
- **About 10% of hospital patients suffer adverse effects** (United Kingdom, *An Organization with a Memory*, Department of Health, 1999)

12

Statistics

The World Alliance for Patient Safety reports that the ***risk of health care-associated infection in developing countries is 2 to 20 times higher*** than in developed countries…and up to 10% of patients admitted to modern hospitals in the developed world acquire one or more infections. **Poor populations** are at even higher risk.

13

No Health Workers, No Care.

- The message in the World Health Report 2006 (WHR) is simple - without health workers, the key global health challenges cannot be met.
- The report reveals a shortage of almost 4.3 million doctors, midwives, nurses and support workers worldwide.
- The shortage is most severe in the poorest countries, where health workers are most needed.

14

Ethical Principles Guiding Health Care Decision-Making

Beneficence

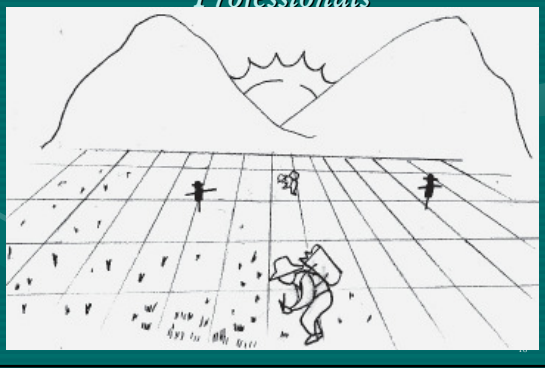
To protect and promote the best interests of the individual and community at all times

Maleficence

To do no harm

15

Growing Competent Health Professionals



Defining Competence

- A **level of performance** demonstrating the effective application of:
  - **Knowledge and attitude**
  - **Skill**
  - **Judgment**

17

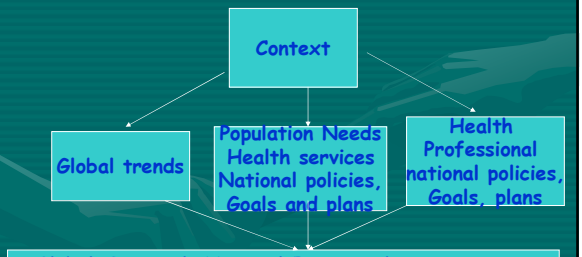
Performance abilities

- **Knowledge, understanding and judgment**
- **Range of skills – thinking, technical, and interpersonal**
- **A range of personal attributes and attitudes**

18

Annex 22. Liberalization of Professional Practice: Moving Forward Across Borders to Improve Access, Service Delivery, Population Health Outcomes

The Context (Environment) for Development of Competencies



19

Core Health Professional Competencies to Address Population Health Needs

- Epidemiology, health determinants, public health
- **Communication (verbal and non-verbal—direct, indirect use);**
- **Inter-professional collaboration, team-building and teamwork**
- Community partnerships, empowerment
- Accountability, organizational effectiveness
- **Entry to practice safety in increasingly complex practice environments**
- Continuous Quality improvement

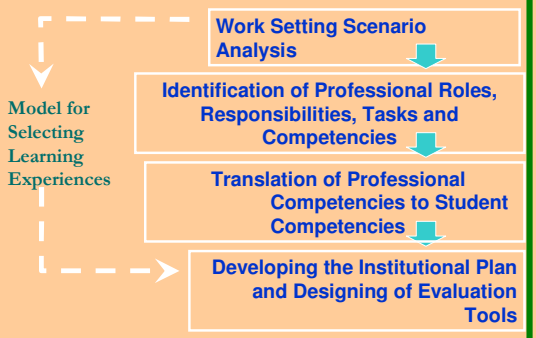
20

Core Health Professional Competencies to Address Population Health Needs

- Cost analysis; health economics
- **Cultural competence**
- Health promotion, disease prevention
- Strategic planning, policy-making
- Mobilization, advocacy, coalition-building
- **Evidence-base for practice**

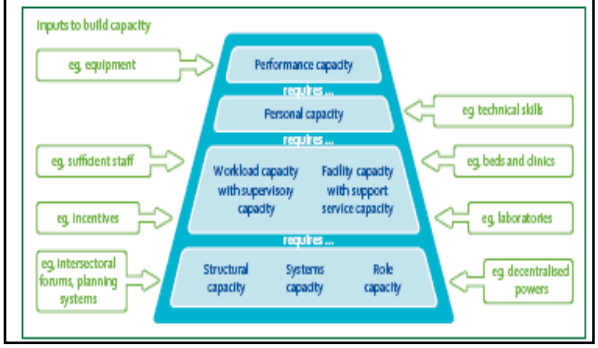
21

Phases in Developing the Competency-Based Curriculum at UP



Effective Capacity-Building Pyramid

Potter & Brough. Health Policy and Planning, 2004:19, 336-345



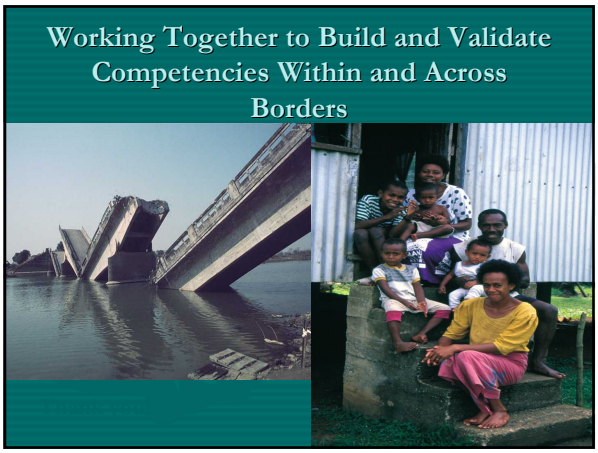
Principles Supporting Health Trade in Health Servicves

- **Role competency**
- **Systems, supports**
- **Regulatory needs**
- **Planning, monitoring**
- **Compensation, workplace safety**
- **New demands, functions**
- **Economic analyzes**
- **Health system quality monitoring**
- **Role complementarity and integration**

[ICM, 2008]

24

Annex 22. Liberalization of Professional Practice: Moving Forward Across Borders to Improve Access, Service Delivery, Population Health Outcomes



Annex 23. Cooperation Agreements to Address Equity Issues: Case of the Philippines

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COOPERATION AGREEMENTS TO ADDRESS EQUITY ISSUES

FELY MARILYN LORENZO DRPH
COLLEGE OF PUBLIC HEALTH , UP MANILA

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Presentation Outline

- Managed Migration
- Policy Development Criteria
- Philippine Experiences in Bilateral and Multilateral Agreements
- Conclusions

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Vision and Goal: Managed Migration

- Should facilitate both
  - development goals of source countries and
  - efficiency goals of destination countries
- Involves national
  - policy reforms,
  - international agreements,
  - cooperative education program by source and destination country institutions,
  - and health sector development projects.

(Commonwealth Secretariat, 2005)

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Migration Related Policy Categories

1. Recruitment, Entry, and Citizenship Policies
2. Licensure and Scope of Practice
3. Welfare and Human Resource Development
4. Retention Policies
5. Re- entry of Migrants (Brain Gain)
   - Permanent
   - Temporary (Brain Circulation)
6. Skill Mix
7. Poverty Alleviation and Social Development

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Policy Development Criteria

1. Should achieve equity and efficiency
2. Promote policy Coherence
3. Promote protection and safety of health Outcomes

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Policy Goals

- Equity – Nurse Distribution
- Effectiveness- MDGs
- Efficiency- Outputs met
- Security – Safety – Attainment of Health Outcomes

Annex 23. Cooperation Agreements to Address Equity Issues: Case of the Philippines

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PHILIPPINE BILATERAL/MULTILATERAL AGREEMENTS

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Review of Philippine Bilateral Agreements

Precondition1-Legal Access to Labor Markets

Good Practice Policy Elements:

- Share information in order to better match labor supply and demand
- Build capacity to improve human resource development, technology transfers, and skills training
- Identify all stakeholders and involve countries of origin, NGOs as well as international organizations in the selection and recruitment of workers

(Based on Compendium of Good Practice Policy Elements in Bilateral Temporary Labor Arrangements, Global Forum on Migration and Development,2009)

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Review of Philippine Bilateral Agreements

Precondition1-Legal Access to Labor Markets

Good Practice Policy Elements:

- Enhance and enable specific types of temporary labor migration, including circular and sector-specific migration
- Enable equal access for women to employment
- Recognize skills and qualifications to facilitate entry into destination labor market
- Address irregular migration with arrangements for legal migration opportunities as an option to restrain irregular movements of people

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Review of Philippine Bilateral Agreements

Precondition2-Protection by improving Work Outcomes and Skills of Migrants

2a. Monitoring and Evaluation of Employment

Good Practice Policy Elements:

- Inform workers of legal migration opportunities and of their rights and obligations
- Protect migrant workers from recruitment fees and high transportation costs
- Guarantee fair work and wage conditions

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Review of Philippine Bilateral Agreements

2a. Monitoring and Evaluation of Employment

- Facilitate equal access of female migrant workers
- Ease access to financial systems and enhance financial transfers
- Ensure the same health care and social security benefits for migrant workers as for local workers
- Ensure Enforcement
- Integrate monitoring and evaluation measures

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Review of Philippine Bilateral Agreements

2b. Improving work skills and outcomes

Good Practice Policy Elements:

- Provide pre-departure language training and culture orientation
- Cooperate among countries of origin to protect migrant workers in countries of destination
- Promote inclusion of migrants in society of destination country
- Facilitate family unification

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Review of Philippine Bilateral Agreements

Precondition 3 – Ensuring temporariness of Migration

Good Practice Policy Elements:

- Ease reintegration and recognition of skills
- Provide for the portability of retirement pensions, social security; health benefits

Miscellaneous Arrangements

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Best Practices specifically for HRH

- RP-UK (2003)
- RP- (DOLE) – Saskatchawan, Canada MOU (2006)
- RP – Manitoba, Canada MOU (2006)
- RP- British Columbia, Canada, MOU (2006)
- RP- Alberta, Canada, MOU (2006)
- RP- Japan (JPEPA) , 2006
- RP-Bahrain MOA (2007)
- RP-UAE MOU (2007)

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RP-BAHRAIN MOA ON HEALTH SERVICES COOPERATION

MOA OBJECTIVES:

- Provide an ethical framework that will guide the recruitment policies and procedures of parties
- Create alliances between healthcare and educational institutions
- Provide reintegration for HRH upon return to home country
- Develop mechanisms for sustainability of HRH development
- Promote the development of health-related research institutions

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RP-BAHRAIN MOA ON HEALTH SERVICES COOPERATION

A. Exchange of Human Resources for Health
   1. Recruitment
   2. Rights of Workers
   3. Capacity Building
   4. Mechanisms for Sustainability of the development of HRH
   5. MRA on HRH

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RP-BAHRAIN MOA ON HEALTH SERVICES COOPERATION

B. Scholarships
C. Academic Cooperation on HRH
D. Investments
E. Technology Cooperation

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STATUS: RP-BAHRAIN MOA ON HEALTH SERVICES COOPERATION

Formulation of Implementing Guidelines

- Exchange of HRH
- Investment Cooperation

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MOU between DOLE and Saskatchewan Province, Canada (2006)

Mutual Development of Human Resources

Saskatchewan companies employing workers deployed under the MOU will provide investments or contributions to be used to improve the education and training of nurses in the Philippines

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PRINCIPLES

- Beneficial for source, destination and migrant individuals and families
- Efficient and effective use of investments
- Equity and access to opportunities and resources
- Efficient and transparent governance
- Effective and acceptable collaboration mechanisms

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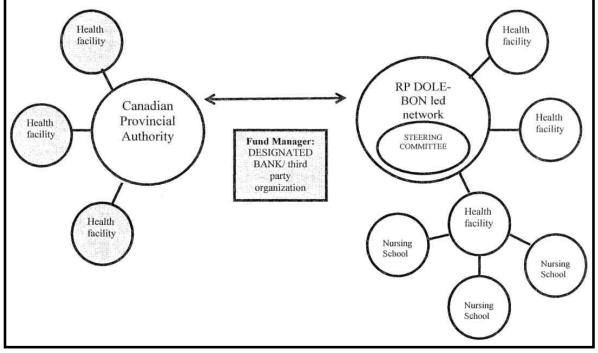
Mediated Twinning Framework



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MOU between DOLE and Saskatchewan Province, Canada (2006)

" Pay back" Investments in :

- training of replenishment of nurses from facilities where they were recruited (hospitals, public health facilities) – mediated twinning arrangements
- facility-based state-of-the-art training institutes through e.g. Philippine Nursing Education Academy (PNEA)
- information systems and exchange of information
- nursing curriculum development and nursing training quality assurance

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MOU between DOLE and Saskatchewan Province, Canada (2006)

STATUS:

Implementing Guidelines are being drafted by the POEA to cover:

- Implementing mechanisms –structures
- Sharing of Information
- Recruitment Mechanisms
- Financing the MOU
- Monitoring and Evaluation

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MULTILATERAL AGREEMENTS MOBILITY OF PERSONS

- ASEAN Mutual Recognition Agreement (MRA)
- Asian Framework Agreement for Services (AFAS)
- Mode 4 Temporary Movement of Business Persons

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MUTUAL RECOGNITION ARRANGEMENT

World Trade Organization (WTO) General Agreement on Trade in Services (GATS) ARTICLE VII

- ALLOWS WTO MEMBERS TO RECOGNIZE THE EDUCATION OR EXPERIENCE OBTAINED
- ALL RECOGNITION MEASURES BE REPORTED TO COUNCIL FOR TRADE IN SERVICES FOR TRANSPARENCY

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MUTUAL RECOGNITION ARRANGEMENT

- Harmonization of technical standards as another means of removing/reducing non-discriminatory trade barriers to market access
- Example of harmonization in both years and content of education -European countries have harmonized 55% of degree programmes

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MUTUAL RECOGNITION ARRANGEMENT

RECOGNITION OF DIPLOMAS, QUALIFICATIONS, LICENCES AND CERTIFICATES ABROAD THROUGH MUTUAL OR UNILATERAL PROCEDURES (RECOGNITION AS A FORM OF NATIONAL TREATMENT)

Investment in nursing curriculum development and nursing training quality assurance

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ASEAN MRA

Agreements in Force:

- Nurses
- Physicians
- Dentists
- Engineers

- Implementing guidelines are being drawn up

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Conclusions

- New HRH bilateral agreements – assure inclusion of ethical framework
- Review bilateral labor agreements that can be renegotiated
- Advocacy, for HRH ethical framework at regional and int'l fora

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Conclusions

- Strengthening of internal coordinating mechanism – government agencies, professional associations, private sector, i.e., recruitment agencies

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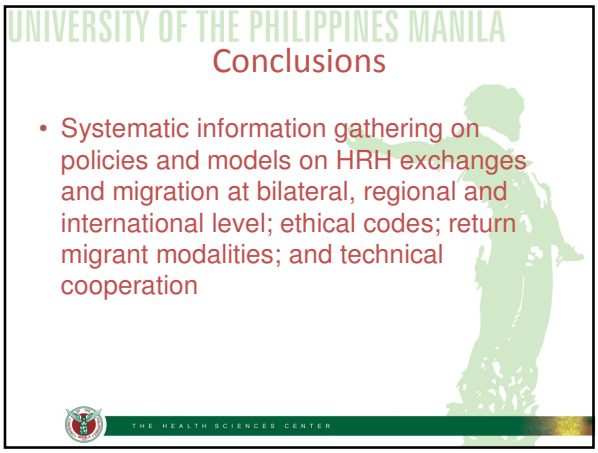
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Conclusions
• Systematic information gathering on policies and models on HRH exchanges and migration at bilateral, regional and international level; ethical codes; return migrant modalities; and technical cooperation
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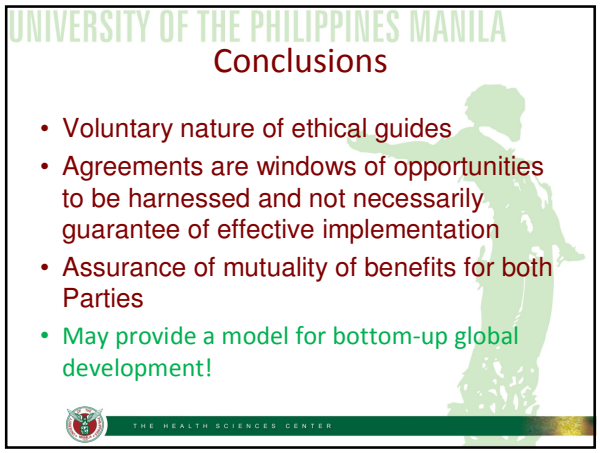
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Conclusions
• Voluntary nature of ethical guides
• Agreements are windows of opportunities to be harnessed and not necessarily guarantee of effective implementation
• Assurance of mutuality of benefits for both Parties
• May provide a model for bottom-up global development!
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THANK YOU VERY MUCH!
MARAMING SALAMAT PO!
MABUHAY!
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APEC Seminar on
Trade in Health Services

Workshop Guidelines
for Day 2, February 10, 2010

Prof. Fely Marilyn E. Lorenzo
Ceferino S. Rodolfo
CONVENORS

Cebu City, Philippines
9-11 February 2010

1

Guide Questions:

1. With all the points raised in this seminar (from the presentations, to the discussions, to the workshops, to the networking, etc.) what do you think are the main issues related to international trade in health services? Please identify at least three issues.
2. Individually reflecting on these issues, what do you think does your country need to better address these issues? What do you think can your country offer to assist other countries better address these issues? (e.g. technology, expertise and experience, data and information, etc.)

2

Suggested Tool

Issue:	
• What can my country offer? What resources does my county have?	• What does my country need? What resources does my country need?

3

Guide Questions:

3. Matching the APEC members' needs and resources, what specific cooperation projects can be pursued? Please identify at least three (3).
4. Please identify the specific actions (action plan) needed to pursue these projects, indicate the timetable, responsible persons or institutions, and resource needed.
5. What is the best approach to foster cooperation? In prioritizing the projects and specifying the timetable, your group may decide to categorize the projects according to some scheme.

4

Possible Categorization of Priority Projects (1/2)

- Example 1**: Based on context, urgency & political acceptability**
  - Short-term: Projects in response to emergencies and natural disasters
  - Medium-term: Projects that involve cooperation in elective, low-cost medical procedures
  - Long-term: Projects that involve cooperation in catastrophic, high-cost medical procedures
- Example 2: **Based on issues**
  - Short-term: Projects related to cooperation in data and information exchange
  - Medium-term: Projects related to cooperation in standards development
  - Long-term: Projects that involve cooperation in harmonization of regulation

5

. . . Categorization of Priority Projects (2/2)

- Example 3: Based on **mode of supply**
  - Short-term: Projects related to Mode 1: Tele-health
  - Medium-term: Projects related to Mode 2: Medical Tourism
  - Long-term: Projects related to Modes 3&4: Investments & Migration

Let's agree on how to categorize!

6

Output

	Project Prioritization		
	Short-term (within 1 to 2 years)	Medium-term (3 to 5 years)	Long-term (beyond 5 years)
• Issue:			
• Cooperation Project:			
• APEC members involved:			
• Specific individuals / institutions / Champions:			
• Actions needed & Timeline / Milestones:			
• Critical Resources needed:			

7

APEC Seminar on Trade in Health Services

Workshop Guidelines for Day 2, February 10, 2010

Prof. Fely Marilyn E. Lorenzo
Ceferino S. Rodolfo
CONVENORS

Cebu City, Philippines
9-11 February 2010

8

General Agreement on Trade in Services (GATS): Health Services

Anthony Amunategui Abad
T.A Advisory Services
8F Citibank Center, Paseo de Roxas, Makati, Philippines
aaabad@Tatrade.net

1

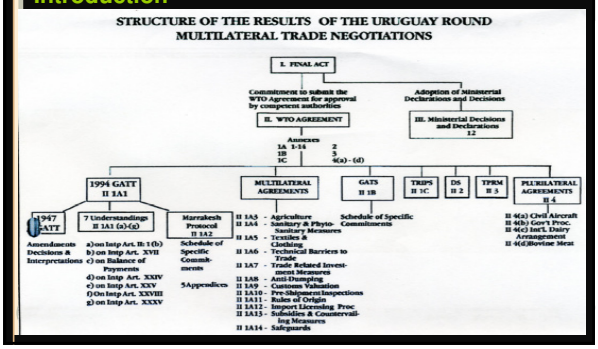
WTO GATS Agreement

Introduction

- GATS is one of a number of agreements under the World Trade Organisation (WTO)
- It limits governments from taking measures that inhibit free trade in services
- Requires countries to provide national treatment to foreign service providers in those service industries that which they have agreed to liberalize under GATS.

WTO GATS Agreement

Introduction



WTO GATS Agreement

GATS Coverage

- Multilateral agreement which was negotiated in the Uruguay Round. It applies to measures affecting trade in services. Measures includes those
  - taken by all government levels (central, regional or local government and authorities); and
  - taken by non-governmental bodies exercising powers delegated by government
  - Law, regulation, rule, procedure, decision, administrative action, or any other form
- Covers all services, except "services supplied in the exercise of government authority" – defined as services that are supplied "neither on a commercial basis, nor in competition with one or more service suppliers".
- Service' includes the production, distribution, marketing, sale and delivery of that service.

WTO GATS Agreement

GATS Coverage – Services exempted

- GATS does not cover 'services supplied in the exercise of governmental authority. A service supplied in the exercise of governmental authority is defined as any service which is supplied :
  - neither on a commercial basis
  - nor in competition with one or more service suppliers

WTO GATS Agreement

GATS Objectives & Structure

- Objectives:
  - Ease trade in services
  - Reduce trade barriers
  - Promote liberalization of trade in services
- Structure (GATS consists of):
  - Framework Text – which sets out the general concepts, principles and rules that apply to measures affecting the trade in services
  - Annexes – to the agreement, which establish principles and rules for specific sectors and complement the framework text.
  - Specific commitments liberalizing trade within the service sectors and subsectors listed in the national schedule of member countries.

Annex 25. General Agreement on Trade in Services (GATS): Health Services

WTO GATS Agreement

General Rules: GATS OBLIGATIONS "Unconditional & Conditional"

- Unconditional Obligation
  - The first set is top down or "general" obligations applying generally to all services, whether or not scheduled
- Conditional Obligations
  - Secondly, there are specific obligations which each country can choose to individually sign up to in their schedule or aapplicable only to services listed in schedules

WTO GATS Agreement

General / Unconditional Obligations

•Apply to all services whether scheduled or not - Among the important general obligations imposed by the GATS framework are those relating to:

- Extension of Most- Favoured Nation Treatment (MFN)
- Transparency
- Domestic Regulations
- Mutual recognition of the disqualifications required by the supply of services
- Monopolies and business practices
  - Rules governing monopolies and exclusive service suppliers and other business practices restraining competition
- Increased participation of developing countries

WTO GATS Agreement

Conditional Obligations

- With respect to the sectors where specific commitments are undertaken by members, the following must be complied with:
  - Transparency
    - Ensure that all domestic regulations of general application affecting trade in services are administered in a reasonable and objective way;
  - Domestic regulation
    - Maintain or institute tribunals or procedures providing for the review of administrative decisions affecting trade in services;
    - Issue to foreigner suppliers the authorization required for the provision of services within a reasonable period;
  - Payments and Transfer
    - Not to apply restrictions on international transfers and payment, except when the country is a serious balance of payment difficulties.

WTO GATS Agreement

GATS - General Exceptions

• GATS rules cannot be used to prevent measures such as those that are:

- Necessary to protect public morals or maintain public order
- Necessary to protect human, animal or plant life or health
- Necessary to prevent deceptive or fraudulent services
- To protect individual privacy and confidentiality
- Relating to safety
- To collect taxes on traded services or service suppliers
- To protect security interests

WTO GATS Agreement

Degree of market opening & Limitations

- Types of limitations are not allowed in committed service sectors
  - Limitations on Market Access (MA)
    - Quota-type and similar restrictions (e.g. limitation on the number of foreign hospitals; limitation on foreign capital participation)
  - Limitations on National Treatment (NT)
    - Less favourable treatment granted to foreigners (e.g. subsidies reserved for national hospitals)

WTO GATS Agreement

Modes of Supply of Services under GATS "How to Trade in Services"

• The four (4) modes of international service transactions:

Mode 1	Cross-border movement of service products e.g. US firm faxes plans to Philippines
Mode 2	consumption abroad or movement of consumers to the country of importation e.g. Tourism
Mode 3	commercial presence or the establishment of a commercial presence in the country where the service is to be provided e.g. U.S. firm opens branch or representative office in the Philippines
Mode 4	movement of natural persons or temporary movement of natural person to another country, in order to provide the service there. e.g. US trade consultant travels to the Philippines in render services

Annex 25. General Agreement on Trade in Services (GATS): Health Services

WTO GATS Agreement

GATS Categories of Services

- GATS Services cover wide range of economic activities. Services are classified in 12 sectors:
  - Business and professional
  - Communication Services
  - Construction & Engineering Services
  - Distribution Services
  - Education Services
  - Environmental Services
  - Financial (Insurance & Banking)
  - Health Services
  - Tourism & Travel Services
  - Recreation, Cultural & Sporting
  - Transport Services
  - Other Services not included elsewhere.

WTO GATS Agreement

Process of GATS negotiation on services

- Request-offer approach
- Request by trade partners in areas with good supply and export capacity, removal of sector-specific barriers
- Analysis of the request received in consultation with local stakeholders- Consideration of the benefits of allowing a foreign service provider within a sector
- Preparation of an "offer" that provides the maximum market access it can provide to all other members.
- Done in a sector-by-sector basis, then mode by mode in each sector
- National Treatment and Market Access limitation

WTO GATS Agreement

GATS Modification of Commitments

- A member can modify any commitment in its schedule once it has been in place for three years
- First however it must negotiate a necessary compensatory adjustment to its other commitments that leaves all other members no less well off.
- Compensatory adjustments are made on a MFN basis – every country is entitled to them
- Any member that is not happy with this adjustment can refer the matter to arbitration to enforce its right

WTO GATS Agreement

GATS Effects on Health Services

- GATS may force public health to compete on a equal footing with private health care. This could lead to increased costs for patients and cost cutting by health care providers.
- Not for profit trusts and charity groups that provide services like aged care and ambulances will be in direct competition with foreign companies.
- Cultural safety training requirements in nursing may be considered illegal Many health care services (I.e. dentistry physiotherapy and midwifery) are not even included under the category health care but business

WTO GATS Agreement

Trade in Health Services within the GATS Framework

GATS Sectoral Classification	Definition
Professional Services	
a. Medical and dental services	Services mainly aimed at preventing, diagnosing and treating illness through consultations by individual patients without institutional nursing
b. Services provided by midwives, nurses, physiotherapist and paramedical personnel	Services such as supervision during pregnancy and child birth, nursing (without admission) care, advice and prevention for patients at home.
Heath Related and Social Services	
a. Hospital services	Services delivered under the direction of medical doctors chiefly to in-patients aimed at curing, reactivating and/or maintaining health status
b. Other human health services	Ambulance services; residential health facilities services other than hospital services; and other human health services (pathology, virology, blood collection etc.)

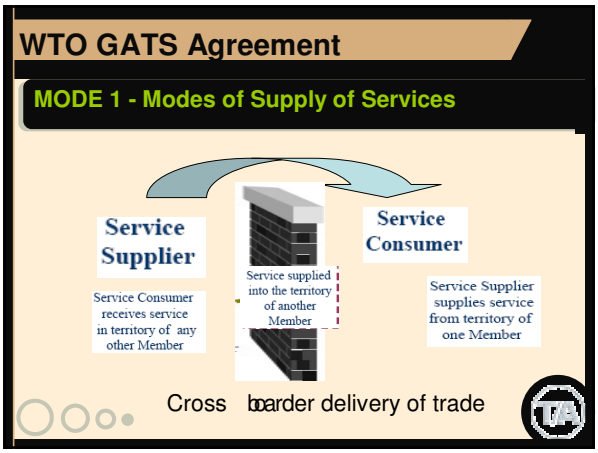
Source: Mortensen 2008

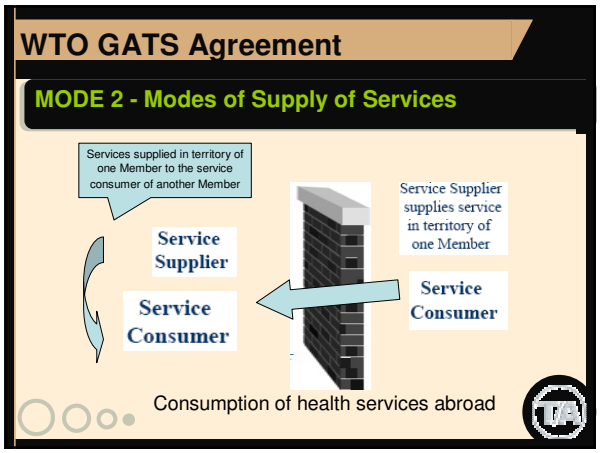
WTO GATS Agreement

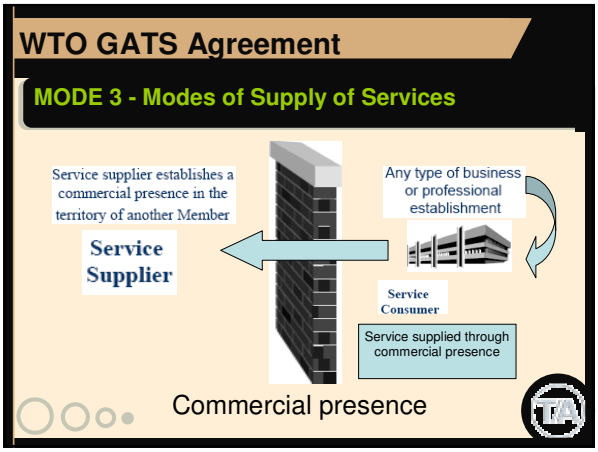
Mode of Trade in Health Services

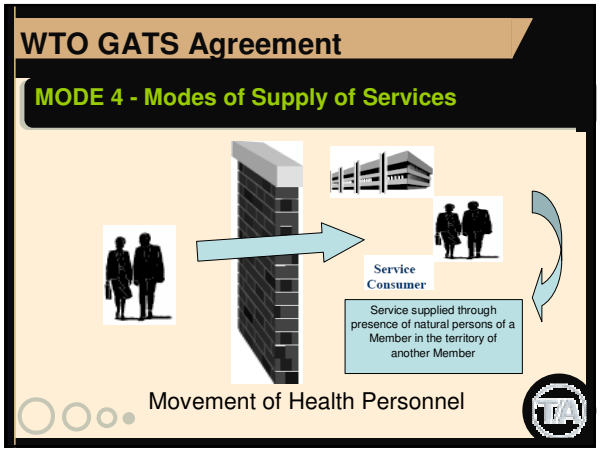
Modes		Areas Affected in Health
1	Cross-border supply	Telehealth, teledermatology, telemedicine, teleradiology; laboratory services; BPO -medical transcription bills and claims processing and other outsourced hospital management functions
2	Consumption abroad	Health and Wellness (spa services and alternative/traditional medicine); cosmetic, dental and eye care and surgery; specialized hospital and surgical care; Medical travel, retirement; health sciences education, training in hospitals
3	Commercial presence	Foreign service providers in hospital operation/ management sector; Investments in hospitals; health insurance; temporary or short-term movement to provide services or consulting assignments
4	Presence of natural persons	Employment of health professionals outside their country of origin

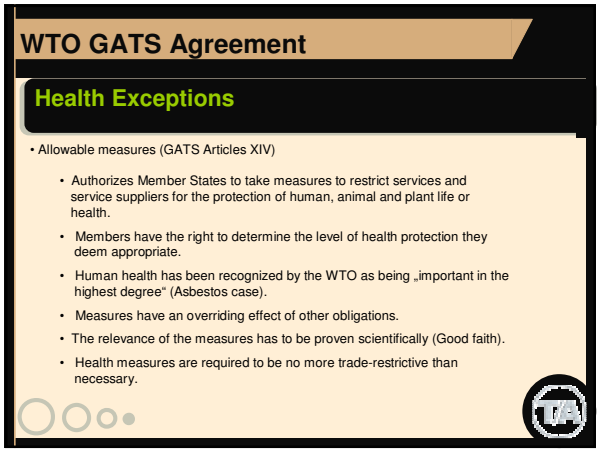
Annex 25. General Agreement on Trade in Services (GATS): Health Services











WTO GATS Agreement

Domestic Health Services

- Major concerns:
  - Deprives governments of policy flexibility;
  - Threatens public health services;
  - Outlaws universal service obligations and subsidized supply;
  - Undermines effective domestic regulation.

WTO GATS Agreement

Must commitments be respected at all costs?

- The GATS allows Members to
  - Renegotiate their commitments against compensation;
  - Depart from them for health and other public policy reasons (Exception provisions); or
  - Introduce restrictions to protect the Balance of Payments.

Trade in Health Services

Issues and Challenges

- Opportunities
  - Create new employment
  - Improve access to new technology
  - Remittances of health personnel overseas
- Risks:
  - Brain drain: permanent loss of health personnel
  - Develop 2-tiered health system – crowd out local population & divert resources to service foreigners
- Challenges:
  - Oppressive & exploitative conditions pushing health professionals to leave
  - Issue on Health workers compensation and benefits
  - Health workers job insecurity

Trade in Health Services

Issues and Challenges

- Developments at the multilateral, regional, and bilateral levels
- Relatively small number of commitments
- Complexity of Trade in Services
- Need to be pro-active

THANK YOU!

T A Advisory Services
8F Citibank Center, Paseo de Roxas
Makati 1226 Philippines
www.TAadvisors.net
aaabad@TAtrade.net

29

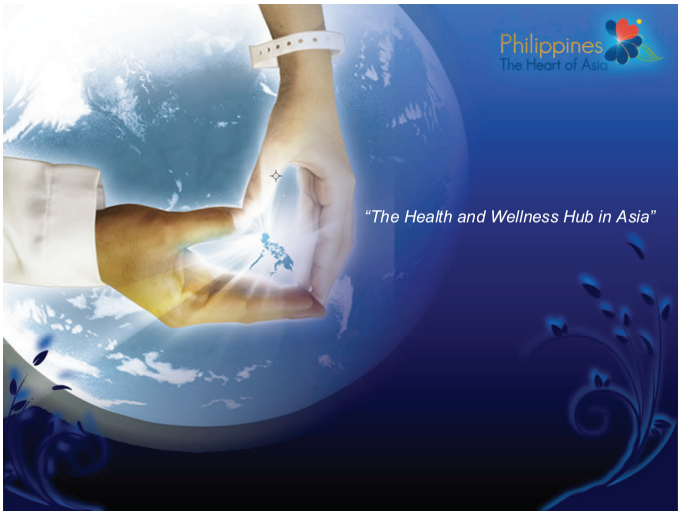
Medical Travel

Advances, Risks, Barriers & Policy Challenges

Focus: Philippines

Joyce Socao-Alumno, MBA

Consultant, Philippine Department of Tourism (Office for Sports & Wellness Tourism)
Secretary General, Health & Wellness Alliance of the Philippines
Chief Strategist, HealthCORE
President & Managing Director, HIM Communications, Inc.



Global Challenge

Provide healthcare services equitably to all the peoples of the world regardless of race and gender.

Deloitte.

Medical tourism: *Update and implications*

Produced by the Deloitte Center for Health Solutions

Deloitte Report (Oct 2009)

- Transitioned from a cottage industry to an acceptable alternative for elective care that is safe and cost effective
- 750,000 Americans traveled abroad for medical care in 2007
- Projections for 2012
  - 1.6 Million Patients
- India's Medical Tourism sector is expected to grow 30 percent annually from 2009 – 2015
- JCI approved hospitals
  - 76 (2005) – 220 (2008)

Country Goals

- Thailand wants to attract two million foreign patients by 2010
- Philippines is hoping for 700,000 patients
- India hopes to generate at least US$ 1 billion a year by 2012
- Singapore hoped to generate US$ 1.5 billion by 2012
- Malaysia expects medical travel reciepts to be US$ 590 million 2011

The Newest Research Findings in Medical Tourism

1st Conference on Medical Tourism
Texas, USA
January 26-28, 2010

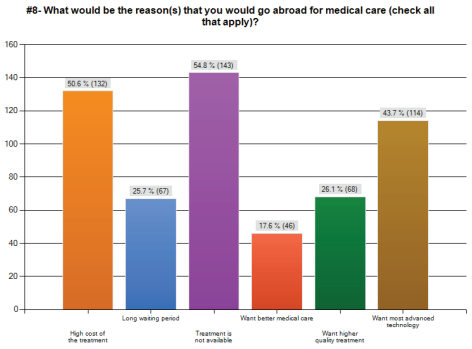
SAMPLES

I. Common Americans surveyed by the students of CMTR
Aged 40+ (261 respondents)

II. Potential Medical Travelers in the US surveyed by Medical Travel Facilitators
US residents (1,572 respondents)

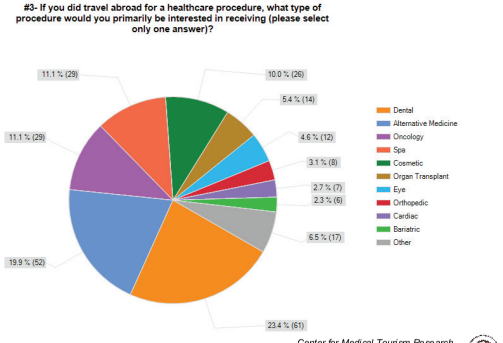
III. Employee Benefit Decision Makers surveyed by CMTR
Average gross income: $2.3bn
Average number of employees: 6,357
(42 respondents)

Common Americans' Views: Reasons



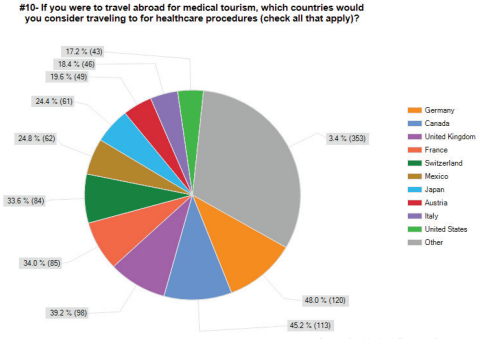
Center for Medical Tourism Research
Texas, USA, February 2010

Common Americans' Views: Procedures



Center for Medical Tourism Research
Texas, USA, February 2010

Common Americans' Views: To What Countries?



Center for Medical Tourism Research
Texas, USA, February 2010

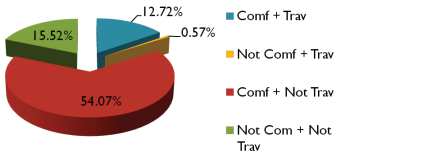
Summary of American's Views

- Comfort level of border states is higher
- Previous travel is an indicator of future travel
- Culture/language is very important to Americans
- American physicians and new medical technologies/procedures are very important

Medical Travel Facilitators' Survey: Comfortable with Medical Travel Abroad?

- Would you be comfortable being treated by a foreign medical provider(s)?

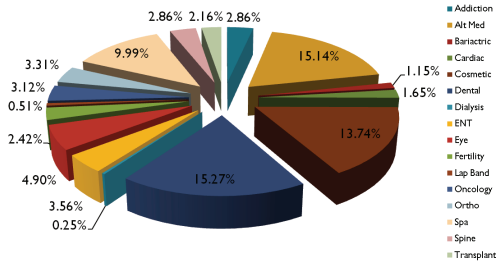
Yes	66.79
No	16.09



Center for Medical Tourism Research Texas, USA, February 2010

Medical Travel Facilitators Survey: If Medical Travel - What

- If you did travel abroad for a healthcare procedure, what type of procedure would you primarily be interested in receiving (please select only one answer)?



Medical Travel Facilitators Survey: Where?

- Mexico 20.18%
- India 11.66%
- UK 5.83%
- Canada 4.93%
- Thailand 3.59%
- Brazil 3.14%
- Korea 3.14%

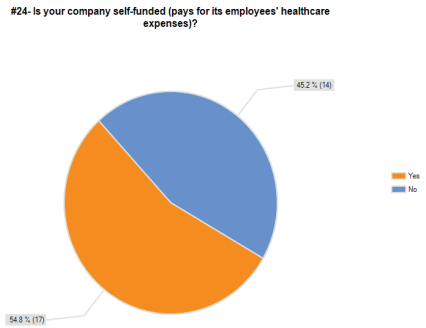
Center for Medical Tourism Research Texas, USA, February 2010

Medical Travel Facilitators Survey: What Procedures?

- Surgery 22.42%
- Dental 18.83%
- Cosmetic 9.87%
- Ortho 4.48%
- Eye 4.04%
- Exec Checkup 3.59%
- Alt Med/CAM 2.3%

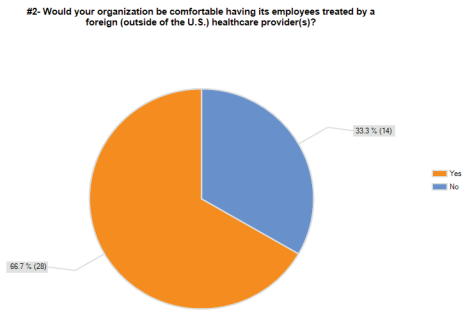
Center for Medical Tourism Research Texas, USA, February 2010

Type of Employer's Insurance



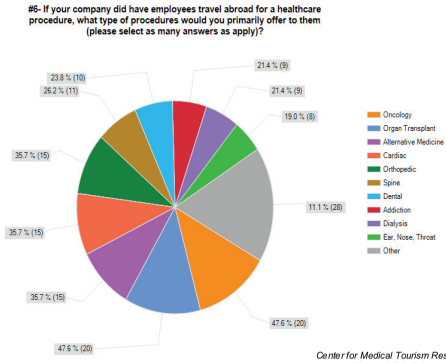
Center for Medical Tourism Research Texas, USA, February 2010

Employer's Views: Comfort



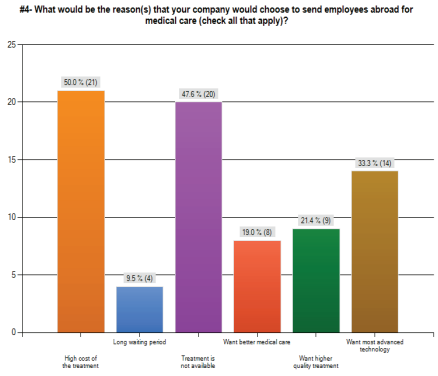
Center for Medical Tourism Research
Texas, USA, February 2010

Employer's Views: Procedures

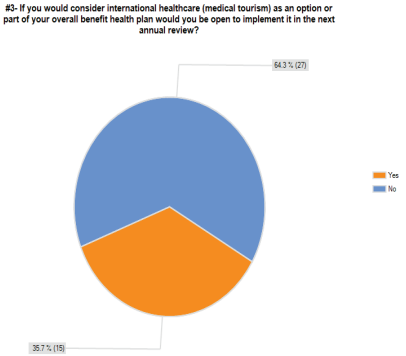


Center for Medical Tourism Research
Texas, USA, February 2010

Employer's Views: Reasons



Employer's Views: Timing



Summary for Employers

- Growing interest
- Not ready to move yet!
- Good news for facilitators
- No specific procedures

Estimate of Medical Travelers in US

- Out of 304mn Americans, 3.8mn are comfortable in traveling for healthcare
- Of these 3.8mn, around 905,000 Americans traveled in 2009 which triangulates roughly with estimates of Horowitz (2007), Deloitte (2009), and Wallace (2008) as well as U.S. DOC airline numbers
- Deloitte estimated that foreign procedures were around $1,410 USD per medical traveler (Weighted Price of a Procedure - 2009)
- Total cost of around $1,276,201,764.26
- It is a billion dollar export from the U.S.

Types of Medical Tourism

- Light
  - –Pharmaceuticals, Check-Ups, Light Dental/ Cosmetic, Spa
- Medium
  - –Heavy Dental, Lasik, Light Medical (Dermatology)
- Heavy
  - –Surgeries, Transplants, Heavy Cosmetic

PRESIDENTIAL EXECUTIVE ORDER NO. 372 *issued on October 18, 2004*

Creating the Public Private Partnership Task Force that will oversee the implementation of Philippine Medical Tourism and Retirement industries to establish a mechanism that will harness the synergy of the public and private sectors approach, and formulate an integrated, market-based, private sector driven master plan for the development of this service industry

Philippines The Heart of Asia

The Philippine Medical Tourism Program was officially launched in 2006

The Philippine Medical Tourism program launch led by President Gloria Macapagal-Arroyo, PPP Task Force Chair Cesar Bautista, Dept. of Health Secretary Francisco Duque III, Dept. of Trade & Industry Secretary Peter Favila, Dept. of Tourism Usec. Cynthia Carrion, and Phil. Retirement Authority Chairman Edgardo Aglipay

Philippines The Heart of Asia

Public-Private Partnership

Government Sector

Department of Health

Department of Tourism

Department of Foreign Affairs

Department of Trade and Industry

Philippine Retirement Authority

Public-Private Partnership Task Force on Globally Competitive Service Industries

Private Sector

SPA ASSOCIATION OF THE PHILIPPINES, INC.

St. Luke's Medical Center One of the World's Best

The Medical City Where Patients are Partners

MAKATI MEDICAL CENTER

Asian Hospital and Medical Center

Health and Wellness Alliance of the Philippines (HEAL Philippines)

A privately registered organization officially recognized by the partnering government agencies to promote the medical, wellness and retirement program of the Philippines

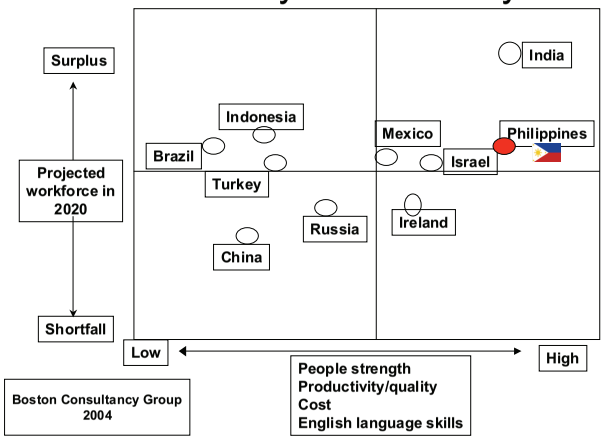
Philippines' Healthcare Pool

Physicians	106,327
Nurses	519,340
Physical Therapists	21,930
Occupational Therapists	2,563
Pharmacists	55,955
Medical Technologists	53,809
Medical Laboratory Technicians	4,021

** Registered and Licensed s of December 31, 2008*

121,000 medical and allied services graduate in 2008 alone. Growing at an average rate of **16% per year** since 2000

Labor Quality and Quantity Index



Boston Consultancy Group 2004

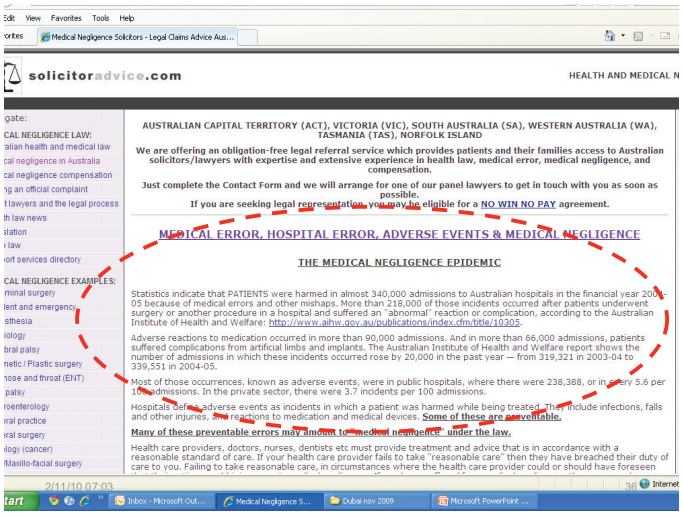
RISKS

Risk #1: Equity in healthcare delivery

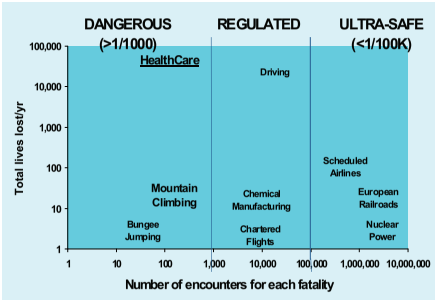
60% of Filipinos who die do not get health professionals' attention - ironic for a country that claims to provide some of the world's best healthcare professionals

Recommendation: Unify standards and regulations of the production, practice and deployment of various health professionals in order to provide service to the underserved communities

Risk #2: Malpractice Claims



How Hazardous Is Healthcare??



"1 in 300 risk of being killed due to medical error in a developed country's hospital, while the risk is 1 in millionth in an air accident"

Liam Donaldson

Chief Medical officer, NHS, UK

As a patient what quality levels would you accept?

90 percent

95 percent

99.9 percent

Take your pick…

If 99.9 % Is Acceptable To You Then…

- Your heart fails to beat 32,00 times each year
- 20,000 wrong drug prescriptions made each year
- 500 surgical operations are performed wrongly every week
- 19,000 babies are dropped by doctors at birth each year

Risk #3: Organ transplant tourism and commercialization

Phil. Renal Disease Registry:
-- 10,000 to 12,000 Filipinos develop end-stage renal disease in 2007

-- 50% require kidney transplant, but only 10% were able to undergo surgery (500) because of insufficient organ supply

-- Only 15 deceased donor organs are transplanted each year which means that the otherwise usable kidneys are buried, and in effect wasted because of Filipino culture which believes that removal of body parts is desecration of the body

THIS LED TO THE THRIVING PHENOMENON OF KIDNEYS AS COMMERCE…..

Professor Daar, Canada: BMJ Organ exporting countries

- Philippines
- Iraq
- China
- India, Pakistan
- South Africa
- Turkey
- Eastern Europe

Dr Yosuke Shimazono (organ importing countries)

- Australia
- Canada
- Israel
- Japan
- Oman
- Saudi Arabia
- USA

TO PREVENT EXPLOITATION OF WOULD-BE DONORS, THE NATIONAL POLICY ON KIDNEY TRANSPLANTATION FROM NON-RELATED DONORS WAS PASSED IN 2008


Philippines Ban Organ Transplant to Foreigners

Thursday, May 01, 2008 at 4:41:38 PM

Organ Donation News

Church leaders and human rights Wednesday welcomed a ban by on organ transplants to foreigner that loopholes may still allow to persist.

The health department Tu organ transplants to foreig punishments for lawbreak trade in poor Filipinos se

The highly influer Conference of the Ph Society of Nephrolc good step in the fig

"That is a step in the right direction," sa Chua, an official of the grouping of the country's renal disease experts.

Republic of the Philippines Department of Health OFFICE OF THE SECRETARY

ADMINISTRATIVE ORDER No. 2008 - 0004

March 1, 2008

SUBJECT: Revised National Policy on Living Non Related Organ Donation and Transplantation and its Implementing Structures

I RATIONALE

Risk #3: Organ transplant tourism and commercialization

Clause ruling that foreigners are not eligible to receive organs from non-related Filipino donors seem effective in curbing "kidney-for-sale-to-foreigners" trade

2007	2008
312 Filipino recipients	274 Filipino recipients
531 Foreign recipients	167 Foreign recipients

DID THIS ANSWER THE PROBLEM OF LACK OF KIDNEYS FOR TRANSPLANTATION TO SAVE LIVES?

Medical TRI[BUNE]

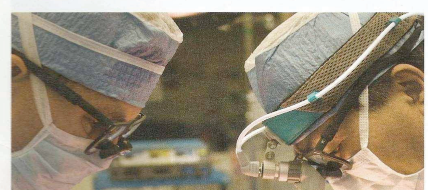
www.medicaltribune.com

Transplant tourists face serious post-op risks

Lynsey Alger

People travelling abroad for kidney transplants face a higher risk of post-operative complications, including an increased risk of acute rejection and more severe infections, compared to those receiving transplants in their home countries, a recent study has found.

As demand for organs increases, increasing numbers of patients are looking abroad for available organs but researchers at the University of California, Los Angeles (UCLA) have warned that "transplant tourism" comes with its own distinct risks, and



OTHER RISKS

- Confidentiality of data
- Internal brain drain
- Dependence on revenues derived from foreign patients
- Migration of healthcare workers
- False claims and advertising to attract foreign patients
- Exploitation of poor citizens by people who come and retire in the country
- Follow-ups, complications and post-operative care

BARRIERS

Health Insurance Portability

Infrastructure
(airport facilities, transportation, etc.)

Language and Cross-Cultural Issues

Brand of the country (security, peace and order)

Hotels and Aviation

Geopolitical Events

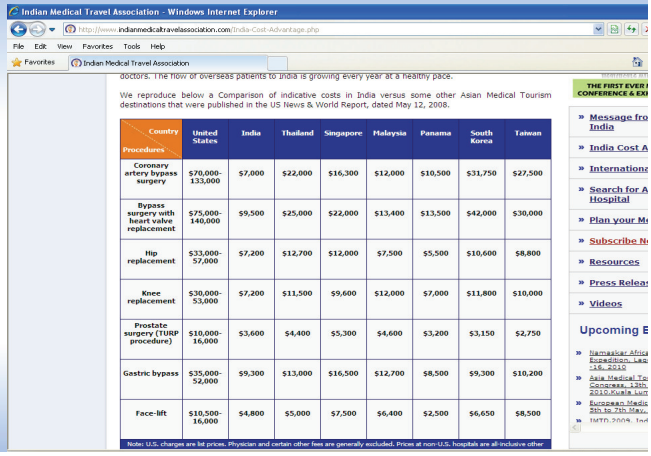
Migration Laws

International uniform standardization of care

Organization Accredited by Joint Commission International

ACCREDITATION CANADA
AGRÉMENT CANADA

Transparency and quality of data

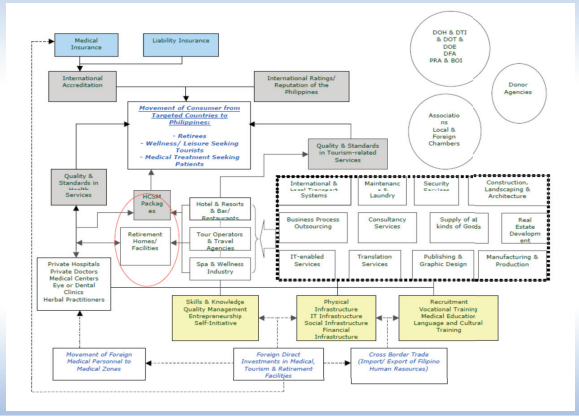


We reproduce below a Comparison of indicative costs in India versus some other Asian Medical Tourism destinations that were published in the US News & World Report, dated May 12, 2008.

Procedures / Country	United States	India	Thailand	Singapore	Malaysia	Panama	South Korea	Taiwan
Coronary artery bypass surgery	$70,000-133,000	$7,000	$22,000	$16,300	$12,000	$10,500	$31,750	$27,500
Bypass surgery with heart valve replacement	$75,000-140,000	$9,500	$25,000	$22,000	$13,400	$13,500	$42,000	$30,000
Hip replacement	$33,000-57,000	$7,200	$12,700	$12,000	$7,500	$5,500	$10,600	$8,800
Knee replacement	$30,000-53,000	$7,200	$11,500	$9,600	$12,000	$7,000	$11,800	$10,000
Prostate surgery (TURP procedure)	$10,000-16,000	$3,600	$4,400	$5,300	$4,600	$3,200	$3,150	$2,750
Gastric bypass	$35,000-52,000	$9,300	$13,000	$16,500	$12,700	$8,500	$9,300	$10,200
Face-lift	$10,500-16,000	$4,800	$5,000	$7,500	$6,400	$2,500	$6,650	$8,500

Note: U.S. charges are list prices. Physician and certain other fees are generally excluded. Prices at non-U.S. hospitals are all-inclusive other

Lack of coordination and collaboration within the medical travel value chain



Lack of available medical tourism packages

Philippines
The Heart of Asia

ADVANCES

Economic Gain

- Foreign Exchange
- Businesses generated
- Jobs created

Reduces external brain drain / Reverse migration

Improved medical infrastructure and implementation of international best practices

Momentum for medical doctors and paramedics to continuously enhance and upgrade their skills

Organization Accredited by Joint Commission International

St. Luke's Medical Center
One of the World's Best

THE MEDICAL CITY
Where Patients are Partners

ACCREDITATION CANADA
AGRÉMENT CANADA

Philippine Heart Center
Center for Excellence in Cardiovascular Care

MANILA DOCTORS HOSPITAL
WORLD-CLASS CARE WITHIN YOUR REACH

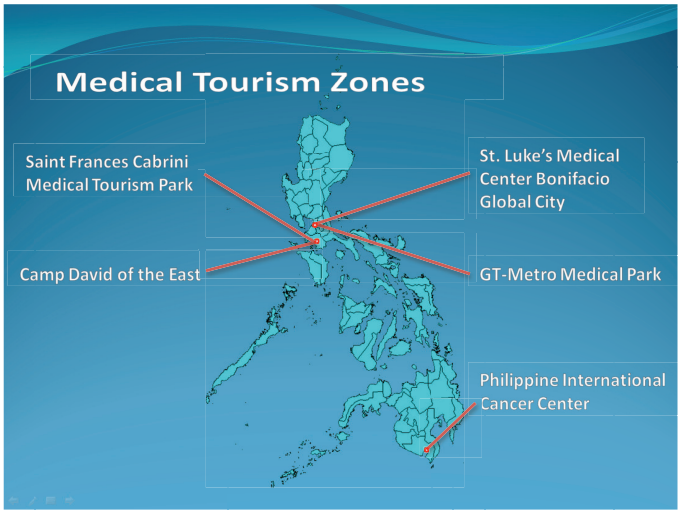
ASIAN EYE INSTITUTE
AEI

clinica manila

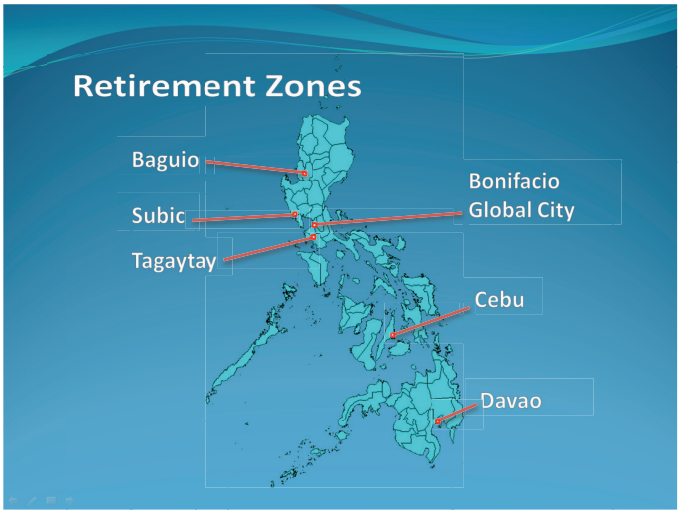
Enhancement of business for other industries like travel and hospitality industry

POLICY CHALLENGES

Medical Tourism Zones



Retirement Zones



Equity in healthcare delivery

How does medical tourism promotion and earnings from this help the local citizens? How does it improve the local healthcare infrastructure?

Medical visa facilitation and migration laws

International agreements on trade in health services

Restriction on foreign doctors practicing in the Philippines

What government policy will ensure the safety and security of international patients?

INTERNATIONAL SUMMIT ON MEDICAL TRAVEL, WELLNESS & RETIREMENT

12 - 15 October 2010 • Makati Shangri-La Hotel, Philippines

Theme: "Globalizing Healthcare: Vision 20/20"

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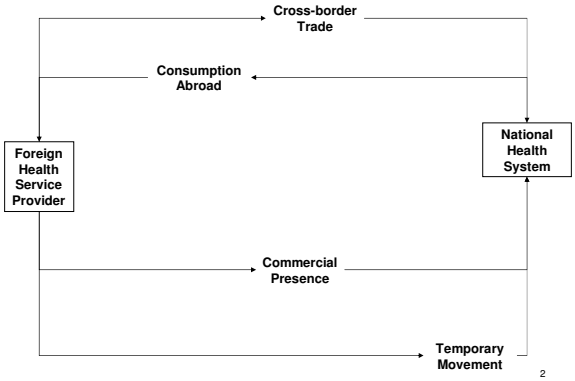
APEC Seminar on Trade in Health Services: A Synthesis

Ceferino Rodolfo
UA&P School of Management

Cebu City, Philippines
9-11 February 2010

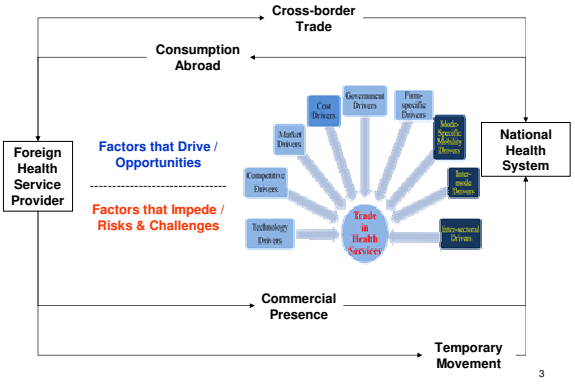
1

Trade in Health Services: Linking Economies



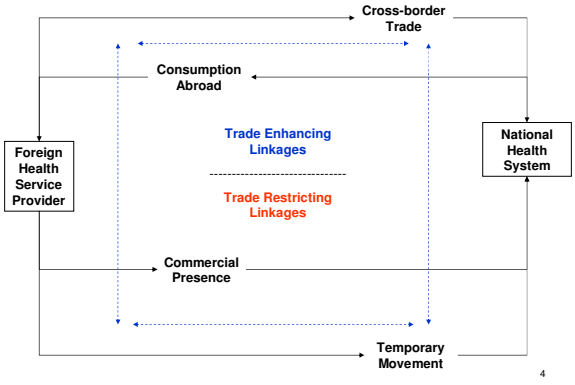
2

Trade in Health Services: Linking Economies



3

Trade in Health Services: Inter-modal Linkages



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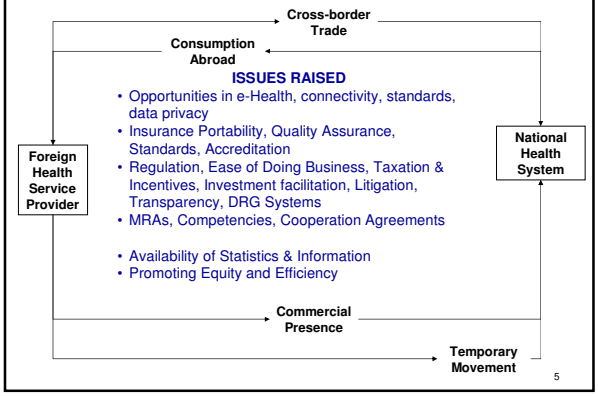
Trade in Health Services: Discussions & Presentations



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Trade in Health Services: Integrating Health Systems

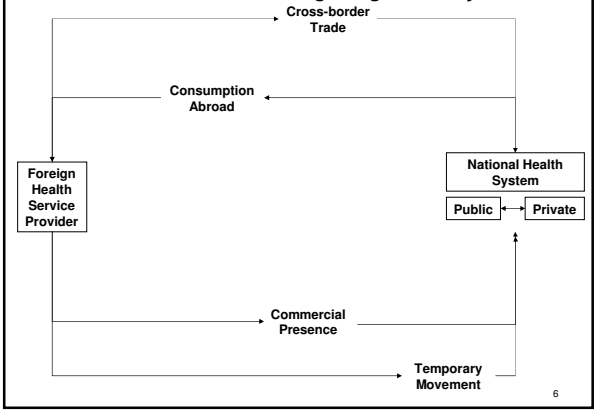

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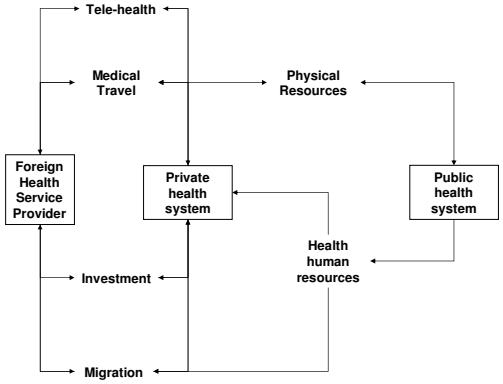
Fig. 1. Trade in Health Services and the Public Health System



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Trade in Health Services: Integrating Health Systems

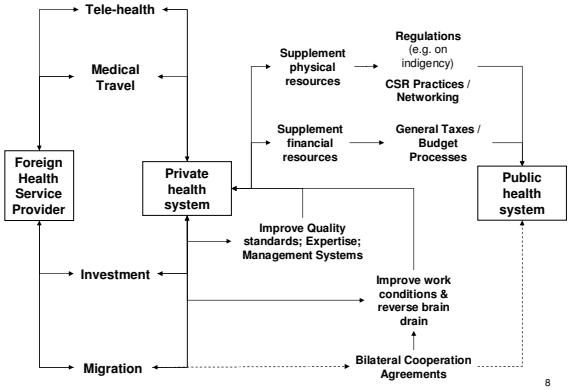

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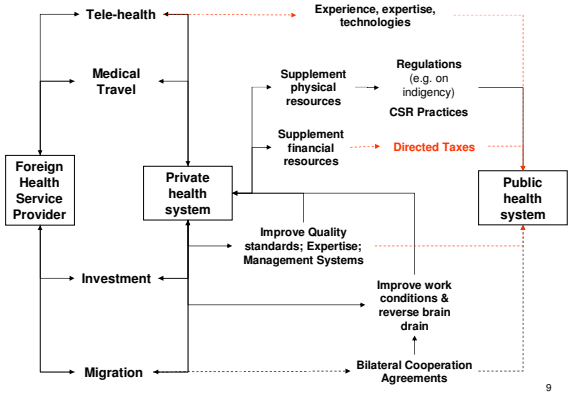
Fig. 2. Trade in Health Services: Integrating Health Systems



9

Key Challenges

- Harnessing linkages among the different modes of supplying trade in health services
- Fostering trade and cooperation among economies
- Integrating health systems (public and private)

10

Potential Cooperation Projects

- Sharing of experiences, information & Networking mechanisms (councils, health services business fora, etc.)
- Studies, Seminars, & Capacity Building (especially for Health Ministries, to enhance participation on Trade in Health Services)
- Statistics & Information
- Standards, quality assurance and accreditation
- Others . . .

11

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UA&P School of Management

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12

Asia-Pacific
Economic Cooperation

APEC Seminar on Health Trade Services

February 9-11, 2010
Shangri-la's Mactan Resort & Spa
Cebu, Philippines

JOINT STATEMENT ON HEALTH SERVICES AND TRADE

We, the undersigned, who attended this APEC Seminar on Trade in Health Services, recognize the deepening relationship between trade and health services, specifically of both the opportunities and risks presented by trade in health services to national health systems.

We agree to foster cooperation among APEC members by actively pursuing projects that ensure the optimal development of international trade in health services in a manner that significantly contributes to the overall improvement of national and APEC-wide health systems, in terms of providing safe, high quality, effective, affordable, and accessible health services to all, especially to the disadvantaged segments of society.

We support the full-implementation and success of any of the following cooperation projects agreed to in this APEC Seminar on Trade in Health Services:

- Mode 1: Cooperate to responsibly develop the use of information and communication technology to promote access to health services across wider geographical areas and populations.

- Mode 2: Cooperate to develop and promote medical travel not only to harness its economic potentials but, more importantly, to maximize its positive impact on health systems of APEC members and of APEC in general.

- Mode 3: Cooperate on projects that promote the flow of foreign investments to countries and sectors which are especially in need of additional financial and technological resources.

- Mode 4: Cooperate to better address and manage the temporary movement, rights and welfare of health human resources in APEC economies, ensuring that the health situation of sending and receiving economies are enhanced.

Signed on 11 February 2010, in Mactan, Cebu, Philippines.

CLOSING REMARKS

BY

DR. NEMESIO T. GAKO
Assistant Secretary
Sectoral Management and Coordination Office
Department of Health

We have come to the final activity for this Seminar. Final yet, we know that this is just the start of more work that needs to be done to pursue better, improved health amid development in trade.

After the two eventful days, I hope that we were not exhausted from the technical discussions, and I hope that as we listened, explored out issues, we found new ideas and learned lessons. We all agree that we have been able to come to sound recommendations and actions in order to ensure the health and well-being in our Region and in each of our economy for whom we have dedicated our careers.

I would like to express grateful appreciation to all of the APEC member economy representatives, resource speakers, guests and colleagues for their valuable presence.

We are especially thankful to each and everyone for your commitments to work on the cooperation projects you have suggested. We all take these forward and we will jointly ensure that these projects are indeed implemented and the outcomes we envision here in Mactan are eventually felt in the whole APEC Region.

Thank you and we wish you safe travel back home. MABUHAY!