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Trade in Health Related Services and GATS

- A Case Study of Pakistan

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Author: Dr. Zafar Mirza

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Preface

The primacy of right of every citizen to health care as enshrined in the 1973 Constitution obligates the government to ensure provision of optimal health care services with equitable access for all citizens. However, 58 years down the road since independence the health care system in the country is suffering from a protracted syndrome indicating underlying inadequacies, incompetence and apathy.

Though the stated official policy remains focused around the popular slogan of "Health for All", citizen's access to public health care and its quality is fast eroding. The 20:80 ratios of health services provided by the public and private sectors till a decade ago has continuously shifted towards private services and it has been reported recently to have changed to 12:88. The public health system is gasping for oxygen and consumers are getting increasingly suspicious about its ability to offer any improvement in quantity and quality of care and services.

All this is going to change further, for the worst, as Pakistan officially endorsed the free trade World Trade Organization (WTO) treaties, aiming to extend the free market in the provision of traditional public services. WTO treaties like Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS) and General Agreement on Trade in Services (GATS) that impact directly on the nature, extent, cost and quality of health care.

In 2001, TheNetwork studied and analyzed the implications of TRIPS on public health through its foundation publication *WTO/TRIPS, Pharmaceuticals and Public Health: Impacts and Strategies.* This is the second paper related to international trade and health care sector. This study examines the threat and opportunities, which GATS poses to health related services in Pakistan.

There is a danger that, under pressure to make commitments under GATS, Pakistan will further liberalize health care services before the proper consumer protection, competition and regulatory structures are developed and introduced. The GATS is likely to distract health care policy and development funding away from the public sector to private sector.

This study provides an overview of the basic structure of GATS, the patterns of Pakistan's current commitments in health services and of limitations frequently used in this context. It looks at the challenge to health services themselves, including the potential for increased inequity, fragmentation of health systems and further marginalization of the public sector as a result of the increased liberalization of health care sector. The concluding section discusses and analyses Pakistan's competitiveness in all four modes of supply under GATS and presents the possibilities of pursuing basic policy objectives in a more open environment and indicates issues that may have to be dealt within current negotiations on services.

I would like to acknowledge the extensive contribution in writing of this paper from Dr. Zafar Mirza, and dedicated assistance from Hafiz Aziz-ur-Rehman, Abdul Hafeez and Muddassar Alam.

Ayyaz Kiani
Executive Coordinator
TheNetwork for Consumer Protection

1. Introduction

"...there is a concern about how progressive liberalization in health services in developing countries is going to affect the already iniquitous health sector."

Trade in health services between countries is not a new phenomenon. Patients and medical students have been traveling to foreign countries in search of better and economic treatments, studies and trainings. The advent of GATS require WTO members to progressively liberalize their services sector, in terms of providing and seeking market access to each others' services providers for better business opportunities and expanding choices for consumers. Health services are also on the anvil in the context of international trade under GATS; however there is no compulsion on any country to make specific commitments in any sector. Countries make commitments in specific sectors presumably after analysis of their comparative advantages in those sectors or as a part of negotiation strategy. Once commitments are made then it is difficult to withdraw them and country becomes bound to provide market access to foreign service providers. In case of social services, however GATS has alerted many quarters about the ways in which liberalization is going to affect the already inadequate services in developing countries e.g. there is a concern about how progressive liberalization in health services in developing countries is going to affect the already iniquitous health sector.

This study is to analyze the situation in Pakistan with reference to trade in health services at present and in future. What specific commitments Pakistan has made in which health services, in what possible ways the trade in health services in Pakistan is going to change in future, what are Pakistan's comparative advantages in health services, which sector of society is going to gain from these businesses and what would be implications on the equity in health because of these developments in Pakistan - are few of the questions which the study attempts to address. It begins by providing overviews of history and quantum of trade and services in Pakistan and by profiling the health situation in the country and then moves on to introduce the GATS agreement and Pakistan's specific commitments in health before analyzing these commitments and their potential impacts.

The study is based upon and guided by the *General Framework for Country Analysis,* developed and produced as a draft working paper by Rupa Chanda, Richard Smith and Nick Drager under the Globalization, Trade and Health program of World Health Organization as part of its initiative on international trade in health services. This initiative is aimed at collecting systematic and comprehensive qualitative and quantitative information on trade in health services for a wide range of countries across different regions.

2. An overview of trade in Pakistan

2.1 History and quantum of trade in Pakistan

Pakistan got independence in 1947. In 1948/49, 99% of our exports were in five primary commodities: raw jute, raw cotton, raw wool, hides and skins, and tea. In 1950s and 60s Pakistan adopted polices of import substituting industrialization during which domestic industry was provided protection through high tariffs. A new policy thinking started setting in towards the late 1960s according to which the protectionist trade regime in Pakistan was held responsible for gross inefficiencies in the industrial structure. This gave rise to a new liberal view about the trade policy. The separation of East Pakistan was a major below to united Pakistan's trade in 1971. In 1969/70, 47% of our total exports were made up of raw jute and jute related manufactured products and all of it was originating from East Pakistan. 1972 saw a major rupee devaluation (56%) with its serious repercussions on the economy. Senior Bhutto's era (1971-77) was characterized by a lack of any explicit export policy. Zia's regime (1977-88) started liberalizing the economy and the trade policy. There were frequent tariff reductions during his years though still in 1986 nominal tariff rates for manufacturing industries in Pakistan were among the highest in the world.

Last three decades, since 1971, have seen a considerable change in the nature of Pakistan's trade. Exports in primary commodities fell from 99% in

Box - 1: Beginning of Trade Liberalization in Pakistan

Pakistan agreed for Structural Adjustment Program in 1988, which included trade sector reform as a major plank in the strategy. Since then there has been a drastic shift in the trade policy and industrial development. The budget announced in June 1988, maximum duty rate on imports was reduced from a range of 150%-225% to 125%. This change affected close to 400 items. Pakistan agreed extensive changes in its trade regime with International Monetary Fund (IMF) many of which had been fulfilled by 1993. The maximum tariff had been reduced from 225% to 90%, import licensing was abolished (except for items on negative list) and resident Pakistanis were allowed for the first time to open foreign currency accounts in 1991.

The current level of tariff in Pakistan is 25% on scores of items and it has gradually been reduced since the start of the Structural Adjustment Program. Pakistan has also committed to the WTO to bring down tariff rate on a range of items but currently it is being asked to bring the items outside the purview of the IMF-sponsored rates of 25 % into its scope for meeting the WTO requirements.

1948/49 to 45% in 1971/72 and further to 11% in 1994/95. Today more than 65% of our exports are in manufactured goods although around 75% of which are dependent on a single commodity i.e. cotton.

Pakistan's share in world exports has declined from 0.21 percent in 1990 to 0.15 percent in 2000. The trade sector has a 15.5% of share in our GDP and it is projected to grow by 4.1% according to Government's "Ten Year Perspective Development Plan 2001-11.

Pakistan is gradually improving its international trade performance. While it still lags the merchandise trade driven Asian economies, Pakistan is slowly getting its act together, with exports and imports graduating to a higher growth trajectory. Real GDP grew by 8.4% (2004-05) as against 6.4 percent last year and surpassed the target (6.6%) for the year. Economic growth at 8.4% (2004-05) reached its highest level in two decades, the fifth time in the country's history that it exceeded 8% growth mark. Trade contribution to GDP (merchandise trade/GDP ratio) stood at 28.9% (2004-05) slightly improved as compared to 28% in last fiscal year (2003-04).

Exports were targeted to grow by 11.3 percent in 2004-05 - rising from $ 12.313 billion last year to $ 13.7 billion this year. Exports were up by 14.6 percent during the first nine months of the FY 2004-05 - rising to $ 10206.6 million from $ 8905.2 million in the same period last year. Pakistan lost $ 245.3 million on the export of major items during July-March 2004-05 due to lower export prices prevailing in the international market.

Imports were targeted to grow by 7.1 percent for the FY 2004-05 but instead Pakistan's imports were up by 37.8 percent in the first nine months of the current fiscal year. An exceptionally strong growth of 41.5 percent in the non-food non-oil imports (In particular, imports of machinery 54.9%, chemicals 32.9% and metal group 79.6%), which was in line with robust growth in the economy, caused a relatively larger increase in over all imports than exports.

As a result of the developments in exports and imports, Pakistan's trade deficit has widened beyond target for the current fiscal year owing to a much faster increase in imports compared with exports. During July-March, 2004-05 trade deficit amounted to $ 4262.0 million and was up sharply from $ 1592.2 million in the same period last year.

The composition of Pakistan's exports has changed significantly over the years. The principal variations encompass a steep fall in the shares of Primary and Semi-manufactured exports with a corresponding increase in the share of Manufactured Goods. During July-December of the current fiscal year (2004-05), the share of Primary Commodities remained flat at 10%, Semi-Manufactures fell by two percentage points and the share of Manufactured

Goods moved upward from 78% to 80% over the same period last year due to larger share of value added exports. However, Pakistan still relies heavily on the labor intensive and low value added exports.

Pakistan's exports are highly concentrated in a few items namely, cotton, leather, rice, synthetic textiles and sports goods. These five categories of exports accounted for 79.3 percent of total exports during 2003-04 with Cotton alone contributing 62.3 percent, followed by leather (5.4%), rice (5.2%) and synthetic textiles (3.8%). Such a high degree of concentration of exports in few items is a major source of instability in export earnings. Although Pakistan trades with a large number of countries its exports nevertheless, are highly concentrated in few countries. About one-half of Pakistan's exports went to seven countries namely, the USA (25.6%), Germany (4.9%), Japan (1.5%), the UK (7%), Hong Kong (4.2%), Dubai (2.4%) and Saudi Arabia (2.6%). Among these countries, the maximum export proceeds have come from USA making up approximately one-fourth of the total. Japan's share (July-October 2004-05) has slightly picked up after exhibiting a continuous decline on account of a protracted recession in the Japanese economy. The share of exports to Germany, the UK, Hong Kong and Saudi Arabia remained relatively stagnant while that of Dubai has declined mainly due to textile manufactures.

“Pakistan still relies heavily on the labor intensive and low value added exports.”

The inflation rate which was at 5.7 percent in 1998-99, has been reduced to 3.6 percent in 1999-2000 and further to 3.1 percent in 2002-03 (the lowest in the last three decades). This low level of inflation has been achieved as a result of strict fiscal discipline. Inflation began to pick up by reaching as high as 8.5% (2003-2004) and now stood at above 12%. Cognizant of the impact of inflation on the economy, most notably it's adverse and disproportionate effect on the poor and vulnerable segments of society as well as its wider effect on purchasing power of the fixed-income group.[1]

2.2 Pakistan and the WTO

The same year that Pakistan came into being, it also became one of the 18 founding members of the General Agreement on Tariff and Trade (GATT). Since then Pakistan has taken part in all the international rounds of trade negotiations till the "Marrakesh Agreement Establishing the World Trade Organization" was signed on 14 April 1994 when Pakistan became one of the 124 founding members to create a new World Trade Organization.

Within WTO, Pakistan has been an active member. It carefully balances its position between different developing countries groupings for its common interests and solidarity and developed countries for its other economic

Box - 2: Govt. of Pakistan: Institutional Arrangements for WTO

Pakistan takes part in the WTO deliberations most of the times through its Geneva mission representatives. Back home, there is a Federal Ministry of Commerce (MoC) headed by Federal Minister of Commerce, which is responsible for trade matters. A special "WTO Wing" has been created by the MoC, which is headed by a senior bureaucrat (Joint Secretary). This wing monitor and coordinates the WTO related work, has formed national committees on various agreements, undertakes research on important issues and bring together different stakeholders to discuss and advise the government on specific trade related issues.

strategic interests. It has avoided taking radical positions on issues. During Doha Ministerial Conference, Pakistan came up with a proposition of "Development Box" in the context of WTO agreement on agriculture. It was a rare instance that Pakistan tabled and promoted a specific proposal. Lately, Pakistan became a part of Group of 22 countries, which joined hands at Cancun ministerial meeting to put pressure on industrialized countries to fulfill their commitments in agriculture sector i.e. to cut domestic support to their farmers.

Box - 3: Stakeholders: Institutional Arrangements for WTO

Various stakeholders in Pakistan have also organized themselves in the wake of WTO agreements in order to address the challenges and seize the opportunities. Federation of Pakistan Chambers of Commerce and Industries (FPCCI) has established a cell on WTO issues and keep organizing seminars on various WTO related issues. All Pakistan Textile Manufacturers Association (APTMA) is a resourceful and active organization on textile related issues. Representatives of both FPCCI and APTMA are included in the official delegation of Pakistan to the WTO ministerial meetings. Civil society has also become active on various WTO related issues with reference to research and advocacy. Sustainable Agriculture Action Group (SAAG) is actively working on organizing small farmers and WTO Watch Group (WWG) is a civil society initiative to monitor WTO from people's perspective. Pakistan Center for Trade and Sustainable Development (PCTSD) is a new initiative on the model of International Centre for Trade and Sustainable Development (ICTSD), Geneva. Civil Society Organizations active on WTO issues include ActionAid, Sustainable Development Policy Institute (SDPI), TheNetwork for Consumer Protection, Sungi, ShirkatGah and Pakistan Institute of Labor Education & Research (PILER.).

2.3 Current trade policy orientation

Pakistan has been following an open trade regime for the last few years. In his formal Trade Policy 2005-2006 speech the Federal Minister of Commerce mentioned, at the very outset, the principles of (trade) policy formulation of Pakistan: deregulation; liberalization and privatization. He also mentioned during his speech that market access is the centerpiece of government's marketing efforts.

“Pakistan has been following an open trade regime for the last few years...the principles of (trade) policy formulation of Pakistan: deregulation; liberalization and privatization.”

3. An overview of health sector in Pakistan

3.1 Key indicators

Pakistan generally has poor health indicators. Some of the key indicators are mentioned in Box-4.

Box - 4: Key Health Indicators[2]

- More than 50% of the population of Pakistan is less than 19 years of age.
- Pakistan suffers with double-burden of disease, with almost equal distribution between communicable and non-communicable diseases.
- Leading causes of loss of healthy life in Pakistan are diarrhea; Acute Respiratory Infection (ARI); tuberculosis (TB); birth diseases; injuries; hypertension; chronic liver diseases; heart diseases; malnutrition and diabetes.
- One child dies every minute mainly from Expanded Programme of Immunisation (EPI) diseases,[a] diarrhea and ARI;
- 400,000 infants die in first year; 80% of births take place at home, either unsupervised or by inadequately trained personnel and 30,000 women die from pregnancy-related causes.
- 25% births are low weight (protein deficiency) and 45% anemia in 4-5 years old children (iron-deficiency).
- 34% under-weight mothers and 65% of women in child bearing age are anemic.
- Pakistan bears 6th largest burden of TB in the world with an incidence of 177 cases per 100,000 population.
- Ratio of public to private expenditure in 1998 is 22:78.[b]

Poverty has risen in Pakistan throughout the 1990s and currently various estimates provide a range from 32 to 40 million people living under absolute poverty line. This combined with the fact the more than 80% of health care is provided by the private sector, which has a stark urban bias leaves a majority of the people to rely on unregulated private health care. Pakistan only spends 0.7% of the GDP on health sector, which is lower than the Asian average i.e. 1.3 %. Keeping in view demand inelasticity in health, people especially poor end up buying unreliable health care through precious resources. Out-of-pocket spending by people is the largest source of health financing in Pakistan.

[a] The EPI was launched in 1994 to fight against five diseases tuberculosis, polio, diphtheria, pertussis and measles. - *Daily Times, October 11, 2004*

[b] The 22:78 ratios of health services provided by the public and private sectors has continuously shifted towards private services and it has been reported recently to have changed to 12:88.

3.2 Organization of health sector

The public sector health infra-structure is composed of 5301 Basic Health Units (BHUs), 552 Rural Health Centers (RHCs), and 916 hospitals including Tehsil Headquarter Hospitals, District Headquarter Hospitals and Teaching Hospitals (tertiary care) which are only located in big urban centers. The total number of hospital beds is 99,908. In terms of health related human resource in the country, there are 1,11,326 registered doctors (population/doctor: 1,359), dentists are 6,127 (population/dentist: 25,107) and 48,444 nurses (population/nurse: 3,175). Apart from these there are 70,000 lady health workers.[3]

Private health sector in Pakistan is relatively huge. It consists of allopathic as well as traditional therapeutic systems and is least regulated. There is relatively little research done on the private health sector which is also important from the point of view of trade in health services. According to one estimate, at present there are 106 big hospitals, 520 small hospitals, 20,000 general practitioners, 300 maternal homes, 340 dispensaries, 420 laboratories, 254 NGOs imparting health care.[4] In traditional system there are 73,878 homeopaths, 45,799 hakims and tabibs and 537 vaids in the country.[5]

"Biggest challenge faced by the health sector in Pakistan is lack of universal and reliable health coverage to the citizens."

3.3 Key challenges in health

Biggest challenge faced by the health sector in Pakistan is lack of universal and reliable health coverage to the citizens. The Article 38 (d) of the Constitution of Pakistan reads: *The State shall...provide basic necessities of life, such as food, clothing. housing, education and medical relief, for all such citizens, irrespective of sex, caste, creed or race, as are permanently or temporarily unable to earn their livelihood on account of infirmity, sickness or unemployment;*. A cursory look at the health care system of Pakistan and the key indicators about its performance are enough to understand that how State has not been able to look after this right of its citizens. The challenge is compounded when one realizes that the State lacks a public health policy vision to fulfill its responsibility.

In 2002, federal Secretary Health made a presentation to Development Forum, a consortium of international donors to provide support to Pakistan. While discussing basis for health sector reforms, federal Secretary Health outlined the key challenges faced by health sector in Pakistan (for details see Box-5, on next page) and also acknowledged awareness at the policy level about critical limitations of the approaches to tackle these challenges. These challenges and limitations of approaches to tackle these, quite succinctly encapsulates the situation.

Box - 5: Key Challenges in Health

- Key issue of population growth and limitation of fertility approach in tackling it.
- Verticality and duplication of programs/projects in the health sector and limitation of departmental approach to address this issue.
- Lack of inter-sectoral coordination and limitation of prevalent sectoral approach.
- Urban tertiary orientation vis-à-vis Primary Health Care (PHC) approach with an effective referral system.
- Relegation of women - their needs and rights and gender-biased approach.
- Neglect of linkages with the private sector, non-governmental organizations (NGOs) and civil society as a whole and limitation of narrow public sector approach.
- Centralized mode of governance to the exclusion of elected bodies with devolved authority/powers at district level.
- Neglect of quality and equity dimensions in health service delivery.
- Lack of institutional capacity, including measurement and monitoring skills.
- Insufficient levels of resource allocation for the health sector.

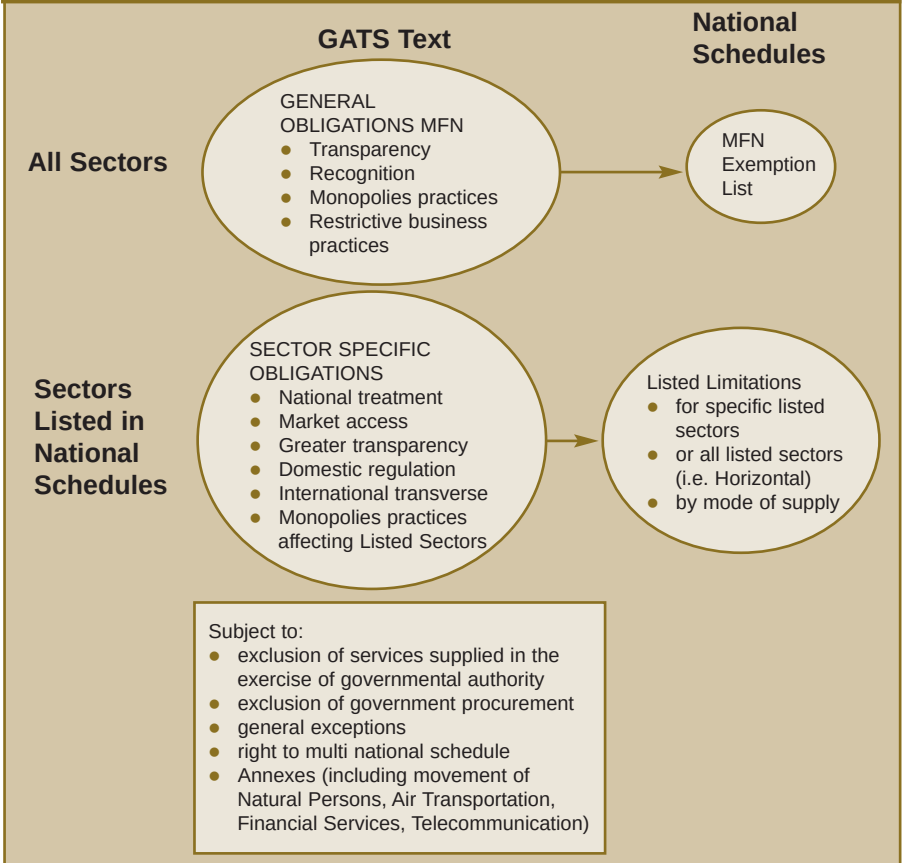
Pakistan embraced the policies of Structural Adjustment Program in 1988 and since then these polices have meant cuts in the development sector, health sector is no exception. Although various researchers acknowledge that despite these constraints, Pakistan, in relative terms, has not done badly during these years.[6]

4. Pakistan and General Agreement on Trade in Services

4.1 General Agreement on Trade in Services

General Agreement on Trade in Services or GATS was one of the new and significant areas included in the multilateral trading system under WTO. It is one the important results of "Final Act Embodying the Results of the Uruguay Round of Multilateral Trade Negotiations". The legal text of the agreement is attached as one of the annexure (Annex 1B) with the "Marrakesh Agreement Establishing the World Trade Organization". The main aim of the GATS is to progressively liberalize trade "as means of promoting

Figure - 1: GATS Framework



Source: VanDuzer, J. Anthony (2004), Health, Education and Social Services in Canada: *The Impact of the GATS,* Study commissioned by the Government of Canada.

the economic growth of all trading partners and the development of developing countries". The agreement was accepted, especially in developing countries, as a part of 'single undertaking" principle in the WTO, without much analysis and debate.[7]

GATS, as a framework agreement consists of 29 articles and annexes. The agreement lays down the general principles and obligations, which define the disciplines on trade in services while the annexes cover the rules for the specific services sectors. The rights and obligations for liberalizing trade in services are reflected in the schedules of specific commitments and the lists of exemptions from Most Favored Nation (MFN) treatment submitted after negotiations by the member governments. These schedules and exemption lists once submitted become integral part of the GATS.

"All services are covered under GATS, except those supplied by a governmental authority... these are ambiguous terms and have been doubted"

All services are covered under GATS, except those supplied by a governmental authority meaning services supplied by the government on non-commercial basis and not in competition with other service suppliers (Art. 3 b, c). These are ambiguous terms and have been doubted by many critics about what exactly is meant by "non-commercial basis" and "not in competition with other service suppliers".[8]

During the Uruguay round, countries submitted their national commitment schedules. A national commitment schedule consist of two parts: one, general obligations or horizontal commitments e.g. MFN, whereby countries, keeping in view their situations, can decide about the exemptions they want to enjoy in MFN treatment, and two, where countries make specific commitments under various service sectors. In each sector they can limit the level of market access and national treatment by specifying it in the national schedule. Article XVI specifies six kinds of limitations which countries can put on their market access commitments.[a]

[a] Article XVI, 2: In sectors where market-access commitments are undertaken, the measures which a Member shall not maintain or adopt either on the basis of a regional subdivision or on the basis of its entire territory, unless otherwise specified in its Schedule, are defined as: (a) limitations on the number of service suppliers whether in the form of numerical quotas, monopolies, exclusive service suppliers or the requirements of an economic needs test; (b) limitations on the total value of service transactions or assets in the form of numerical quotas or the requirement of an economic needs test; (c) limitations on the total number of service operations or on the total quantity of service output expressed in terms of designated numerical units in the form of quotas or the requirement of an economic needs test; (d) limitations on the total number of natural persons that may be employed in a particular service sector or that a service supplier may employ and who are necessary for, and directly related to, the supply of a specific service in the form of numerical quotas or the requirement of an economic needs test; (e) measures which restrict or require specific types of legal entity or joint venture through which a service supplier may supply a service; and (f) limitations on the participation of foreign capital in terms of maximum percentage limit on foreign shareholding or the total value of individual or aggregate foreign investment.

Ongoing Negotiation of Specific Commitments (Article XIX) is provided as an in-built agenda for progressive liberalization of trade in services. In this context some progress has been made since 1995 whereby agreements have been reached in telecommunication and financial services in 1997. Firm timelines for the services negotiations were agreed as part of the Doha package, with initial requests for specific commitments due by June 30, 2002, and initial offers by March 31, 2003. The round of negotiations is concluded by January 1, 2005. A number of countries has said that progress by May (2005) date for revised offers set out by the July Package (WTO Document No. WT/L/579) would help determine the shape of the 'first approximations' of a final Hong Kong agreement that are supposed to emerge by the end of July. Over 40 Members are yet to make their initial offers, including relatively larger developing economies such as the Philippines, South Africa, and Morocco.[9]

"More than half of gross domestic product (GDP) is contributed by the services sector and it absorbs around 45% of the total labor force in the country."

4.2 Services sector in Pakistan[10]

Services are an important component of Pakistan's economy. More than half of gross domestic product (GDP) is contributed by the services sector and it absorbs around 45% of the total labor force in the country. The services are placed under six broad sectors in the national accounts for the purpose of calculating sectoral GDP in Pakistan. Their combined share in GDP has remained around 52-53% on average in the 90s (1990-91 to 1998-99) and these have recorded a combined growth of 4.5% per year during this period. Individual sectoral shares in GDP and growth rates during 1998-99 are: the whole sale and retail trade sector (52.3%); transport, storage and communication (15.4%), public administration and defense (6.1%), ownership of dwellings (5.4%), construction (3.6%); and finance and insurance (2.3%). The remaining services have been grouped under "other services" whose share (8.9%) is slightly bigger than that of public administration and defense. Health services are included in the category of "other services" and its further breakdown is not available.

4.3 Trade in services sector

Balance of payments (BOP) statistics are the major source of information on international trade in services in Pakistan. These are prepared according to the principles laid down in the 4th edition of IMF Balance of Payments Manual. BOP is itself a complete account of all financial transactions, which have direct bearing on the financial sector and ultimately on its net output. Besides merchandize trade and government's loan/aid related transactions

it focuses on the services like shipment, transportation, travel and workers' remittances routed through various modes of service supply defined under the GATS.

"Pakistan has a liberal investment policy whereby equal treatment is extended to local and foreign investors. All economic sectors have been opened up for FDI and 100% foreign equity has been allowed."

Pakistan is a labor surplus country. Its surplus labor in earlier years has been migrating to the United Kingdom (UK) and other Western countries. The oil boom in the Middle East in the 70s opened greater avenues of labor immigration to that region. The United Sates (US) and Canada also provide some job opportunities but mostly for educated and skilled labor. Pakistan experienced export boom of manpower during the period, 1976-77 to 1982-83 when almost 1/3 of its incremental labor force with an average outflow of 138 thousand workers per annum was absorbed in the Middle East. Home remittances (foreign exchange remitted to Pakistan) had increased from US $ 578 million in 1976-77 to US $ 2,886 million in 1982-83. After touching a peak in 1982-83 the remittances have started declining since 1983-84 and with their continued tapering off these had declined to a level as low as US $ 1,055.8 million during 1998-99. The major country sources of these remittances in the selected past years are Middle East, UK, USA, Germany, Norway, Canada and others.

Structural Adjustment Program in Pakistan has a very positive impact on investment inflows. FDI was of US $ 216.2 million in 1989-90 which substantially crossed a one billion mark in 1995-96 (to be exact, $ 1101.7 million) but since then this has started shrinking because of political changes, causing some instability in economic policies and the nuclear explosion race between India and Pakistan since May 1998. In 2003 the Foreign Direct Investment (FDI) in Pakistan, according to World Investment Report was $820 million - 63 per cent more than in 2002, thus parting company with 26 countries of Asia-Pacific region which registered a substantial fall in FDI inflows[11] but still lower than the level in the 1995-96 fiscal. This shows that with macroeconomic stability the FDI inflows are on the rise in Pakistan. The largest country sources of FDI in Pakistan are the USA, the UK, the UAE, and Japan.

Currently, Pakistan has a liberal investment policy whereby equal treatment is extended to local and foreign investors. All economic sectors have been opened up for FDI and 100% foreign equity has been allowed. No government sanctions are required and attractive incentives are provided to investors who have been allowed to remit royalties, technical and franchise fees, capital, profits and dividends.

4.4 Pakistan's schedule of commitments in GATS

In order to progressively liberalize the services sectors under the auspices

of GATS, WTO member countries had to make some commitments to provide market access to other WTO members in their services sectors through *Schedules of Specific Commitments*[a] which as annexes to the GATS have become "integral part" of the agreement. Services sectors were divided into 12 groups with many sub-sectors in each. WTO Document No. MTN.GNS/W/120 of 10th July 1991 made a preliminary attempt to list the services and placed them under twelve broad sectors such as (1) Business; (2) Communication; (3) Construction and Engineering; (4) Distribution; (5) Education; (6) Environment; (7) Financial; (8) Health; (9) Tourism and Travel; (10) Recreation, Cultural and Sporting ; (11) Transport; and (12) "Other". Each national schedule of specific commitments is developed after negotiations with other members and broadly has two sections. In the first section the country mention exemptions (if any) from MFN treatment, which is a *General Obligation* under GATS agreement along with 16 other *General Obligations and Disciplines* which constitute the Part II of the agreement. These general obligations and disciplines are also called Horizontal Commitments which means that these are horizontally or generally applicable to all the specific commitments made in different service sectors unless exemptions to these are mentioned in the national schedule as market limitations, national treatment limitations or any additional limitations. In the second section, sector-specific commitments are mentioned under various sectors and subsectors. Each sector specific commitment has to deal with the mode of supply, market access, national treatment and any additional commitments made by the country. Modes of supply are: cross-country supply; consumption abroad; commercial presence; and movement of natural persons. Market access can be limited, the detail of which is mentioned in the schedule. Likewise, limitations to national treatment are mentioned. If no limitations are mentioned against the market access and national treatment then the commitment is called "unbound".

A specific commitment by the government means that government binds the specific level of market access and national treatment separately for each mode of supply for each activity of services and each commitment is also governed by the MFN exemptions and other general obligations and disciplines. These schedules once submitted become integral part of the

"schedules once submitted become integral part of the GATS...any dilution in the already committed market access is quite difficult and subject to some conditions"

[a] GATS Agreement: *Article XX: Schedules of Specific Commitments:*
1. Each Member shall set out in a schedule the specific commitments it undertakes under Part III of this Agreement. With respect to sectors where such commitments are undertaken, each Schedule shall specify: (a) terms, limitations and conditions on market access; (b) conditions and qualifications on national treatment; (c) undertakings relating to additional commitments; (d) where appropriate the time-frame for implementation of such commitments; and (e) the date of entry into force of such commitments.

"...Pakistan made comprehensive initial commitments... including hospital services under "Health Services and Social Services" group."

GATS, though modification in them for improving market access is encouraged but any dilution in the already committed market access is quite difficult and subject to some conditions like limitation of 3 years before which commitment cannot be changed and also an appropriate compensations also have to be made according to Article XXI of the GATS agreement.[a] These conditions are so tough that, in the words of David Hartridge, former Director of the WTO's Trade in Services Division, these are almost "irreversible".[12] Others have called it as a "lock-in" feature of GATS agreement.[13]

To begin with, Pakistan took a cautious approach in GATS negotiations. Realizing that services sector in Pakistan is comparatively much underdeveloped than in the developed countries and that developed countries under mode 3, to have market access, have clear comparative advantage than Pakistan's comparative advantage in mode 4 as labor surplus country but since this advantage is offset by the restrictions on movement of natural persons, the policy makers adopted an approach to basically maintain a status quo. Since there is no compulsion under the multilateral discipline of the GATS for a member country to make necessarily a specific binding or commitment and bilateral exchange of offers and requests has been permitted to member countries under GATS, Pakistan made comprehensive initial commitments wide Document No. MTN.GNS/W/170 of 20th September in 1993. It covered 20 services activities which fall under 5 service groups, including hospital services under "Health Services and Social Services" group. But these commitments were in the form of conditional offer and were made after consultations with the interested member countries and taking into account the requests made by them. Most importantly Pakistan specified that its offer was conditional subject to the extent and nature of the commitments made by other participants particularly, in the sectors/sub-sectors and mode of

[a] *Article XXI: Modification of Schedules:* 1. (a) A Member (referred to in this Article as the "modifying Member") may modify or withdraw any commitment in its Schedule, at any time after three years have elapsed from the date on which that commitment entered into force, in accordance with the provisions of this Article. (b) A modifying Member shall notify its intent to modify or withdraw a commitment pursuant to this Article to the Council for Trade in Services no later than three months before the intended date of implementation of the modification or withdrawal. 2. (a) At the request of any Member the benefits of which under this Agreement may be affected (referred to in this Article as an "affected Member") by a proposed modification or withdrawal notified under subparagraph 1(b), the modifying Member shall enter into negotiations with a view to reaching agreement on any necessary compensatory adjustment. In such negotiations and agreement, the Members concerned shall endeavour to maintain a general level of mutually advantageous commitments not less favourable to trade than that provided for in Schedules of specific commitments prior to such negotiations. (b) Compensatory adjustments shall be made on a most-favoured-nation basis.

supply of interest to Pakistan especially that relating to the "Movement of Natural Persons". While making these initial commitments Pakistan reserved the right to change them at any stage depending on the satisfactory outcome of the Uruguay Round.[14]

Pakistan had been updating its schedule of specific commitments since September 1993 using first commitments as the basic guidelines. On 15 April 1994, Pakistan submitted its national schedule of commitments wide Document No. GATS/SC/67 (See Appendix), which sets out the main framework of its commitments. These commitments showed improvement in terms of market access and national treatment over the previous ones. Improvements were particularly made in the case of financial and telecommunication services. Since the submission of commitments in 1994, other WTO members, especially from developed countries demanded improvements in MFN and national treatment exemptions particularly in the areas of financial and telecommunications services. Responding to these demands Pakistan submitted two supplements declaring exemptions in the telecommunications (e.g., application of differential counting rates for operators/countries covered in bilateral agreements with Pakistan Telecommunication Company Ltd.) and financial sectors (e.g., ECO ventures).

Para 15 of Doha ministerial declaration provides a schedule for further negotiations between the member countries to liberalize services: *The negotiations on trade in services shall be conducted with a view to promoting the economic growth of all trading partners and the development of developing and least-developed countries. We recognize the work already undertaken in the negotiations, initiated in January 2000 under Article XIX of the General Agreement on Trade in Services, and the large number of proposals submitted by members on a wide range of sectors and several horizontal issues, as well as on movement of natural persons. We reaffirm the Guidelines and Procedures for the Negotiations adopted by the Council for Trade in Services on 28 March 2001 as the basis for continuing the negotiations, with a view to achieving the objectives of the General Agreement on Trade in Services, as stipulated in the Preamble, Article IV and Article XIX of that Agreement. Participants shall submit initial requests for specific commitments by June 30, 2002 and initial offers by March 31, 2003.*

Pakistan has received "Initial Requests" from 18 countries including developing countries like the US, European Union (EU), Japan, Canada, Australia, Norway, Switzerland and from developing countries like Korea, Turkey, India, Malaysia, China, Jordan, and Oman. In these requests almost all the sectors and sub-sectors are covered but there has been more emphasis on Professional Services, Financial Sector, Telecommunication Sector and Environmental Sector. Pakistan has made initial request to 17

countries covering a total of 23 sectors and sub-sectors. Same request has been sent to all countries and the main focus has been on modes 3 and 4 in view of Pakistan's export potential in Services. These requests have also been made to the countries making initial requests to Pakistan. About 25 initial offers have been received so far, most offers are from developed countries like US, EU, Australia, New Zealand, and Switzerland. Some developing countries like Uruguay, Paraguay, Panama, Argentina, and Bahrain have also made initial offers.

According to the record on WTO website, Pakistan had been involved in the following proposals at various times on various GATS related issues in collaboration with other developing countries:

- June 10, 2002: Cuba, Dominican Republic, Kenya, Nigeria, Pakistan, Senegal and Zambia.[a]
- December 6, 2001: Cuba, Pakistan, Senegal, Sri Lanka, Tanzania, Uganda, Zambia and Zimbabwe - "Increasing Participation of Developing Countries in International Trade in Services: Effective Implementation of Article IV of GATS".[b]
- November 30, 2001: Brazil, Colombia, Cuba, Ecuador, Dominican Republic, Guatemala, Honduras, Indonesia, Malaysia, Nicaragua, Pakistan, Panama, Paraguay, Peru, Philippines, Senegal, Uruguay and Venezuela - "Autonomous Liberalization and Developing Countries".[c]
- October 9, 2001: Cuba, Dominican Republic, Haïti, India, Kenya, Pakistan, Peru, Uganda, Venezuela and Zimbabwe.[d]
- November 24, 2000: Argentina, Brazil, Cuba, the Dominican Republic, el Salvador, Honduras, India, Indonesia, Malaysia, Mexico, Nicaragua, Pakistan, Panama, Paraguay, Philippines, Sri Lanka, Thailand, Uruguay, and the members of the ANDEAN Community (Bolivia, Colombia, Ecuador, Peru, Venezuela).[e]

Pakistan's horizontal commitments under *General Obligations and Disciplines* applicable on all of its specific commitments in six services sectors are mentioned in Box-6, on next page.

[a] Document code TN/S/W/3
[b] Document code S/CSS/W/131
[c] Document code S/CSS/W/130
[d] Document code S/CSS/W/114
[e] Document code S/CSS/

Box - 6: Horizontal Commitments under General Obligations and Disciplines

a. **Representative offices of foreign firms; limitations on market access under Mode 3:** In cases of commercial presence (mode 3) as representative offices of foreign companies, these have to be incorporated with Security Exchange Commission of Pakistan and their equity shares can be majority but not more than maximum of 51%.[a] Also expenses of these representative offices shall only be met by remittances from abroad and such offices will only undertake liaison work.

b. **Representative offices of foreign firms; limitations on national treatment under Mode 3:** Acquisition of real estate by non-Pakistani entities and/or persons is subject to authorization on a case-by-case basis keeping into account the purpose and location of the undertaking. Through this limitation government has kept the discretionary control over giving property rights to foreign entities.

c. **Presence of foreign staff; limitations on market access under Mode 4:** The Government has put limitations on the presence of foreign staff of the foreign firm interested in providing a service in Pakistan to a maximum of 50% in case of executive and specialists category. In order to be sure of the expertise of such staff another condition has been put for movement of such persons to Pakistan i.e. such staff members should have been working with that particular firm for a period not less than one year before their transfer to Pakistan. In order for not leaving any ambiguity, the terms "executives" and "specialists" are also clearly defined in the schedule. Apart from executive and specialist category, there have been no other limitations on movement to and presence of other staff categories which is a liberal approach.

Pakistan's Schedule of Specific Commitments covers 47 activities in following six sectors:[15]

Group 1: Business (including professional and computer) services
Group 2: Communication services
Group 3: Construction and related engineering services
Group 7: Financial (insurance and banking) services
Group 8: Health-related and social services
Group 9: Tourism and travel related services

Tourism and related services was a new addition to the list submitted in

[a] This limitation is in conflict with the current Investment Policy of Pakistan whereby 100% equity is allowed to the investors.

1993 and there were substantial changes in Telecommunication (Communications Services) and Financial Services since 1994. All other sectors remain the same as in the above mentioned national schedule.[16]

If one analyze the list of classification of service sectors used by WTO countries on the basis of WTO Document No. MTN.GNS/W/120 in an attempt to shortlist the sectors and sub-sectors which are closely related with health services, one can construct a classification table (for detail see Table-1, on next page)

In this table an attempt has been made to list the sectors and sub-sectors, which can be directly linked with trade in health services. Definite lines are difficult to draw between health related and non-health related sectors because of their overlaps e.g. without using transport and banking services it is not possible to do business in health services between trading partner countries although these services are not included in the above table. Only those services are included which are more directly linked e.g. (health) insurance, franchising etc. It is clear though that health services are not at all limited to "Health Related and Social Services" category.

> *"...health services are not at all limited to "Health Related and Social Services" category"*

Table - 1: Classification of Services: Sectors Related to Health Services						
#	Sector	Sub-sector		Health service		
1	Business services	A	Professional services	h	1	Medical and dental services
		B	Computer and related services	j	2	Services provided by midwives, nurses, physiotherapists and para-medical personnel
				d	3	Data processing services
		C	Research and development services	a	4	R&D services on natural sciences
				c	5	Interdisciplinary R&D services
		F	Other business services	a	6	Advertising services
				b	7	Market research and public opinion polling services
				k	8	Placement and supply services of Personnel
				m	9	Related scientific and technical consulting services
				n	10	Maintenance and repair of equipment (not including maritime vessels, aircraft and other transport equipment)
4	Distribution services	B	Wholesale trade services			
		C	Retailing services			
		D	Franchising			
5	Educational services	C	Higher educational services			
		E	Other educational services			
7	Financial services	A	All insurance and insurance related services	a	11	Life, accident and health insurance services
8	Health related and social services	A	Hospital services			
		B	Other human health services			

5. GATS and trade in health services in Pakistan

5.1 Trade in health services before GATS

Health related services, in one mode or another, have been traded since the creation of Pakistan. However, in this respect two kinds of movement have been taking place from Pakistan to other countries. Firstly, for a post British colonial state, there was an established tradition for people to send their children for higher studies to Britain including for medical education. This tradition still continues though overwhelmingly for post-graduate medical training. Many such students after their post-graduation settle in other countries, of what policy makers have started feeling as a problem. The former Federal Health Minister Dr. Abdul Malik Kansi said in 2002 that Pakistan is facing acute scarcity of health specialists as most of them have moved abroad in search of better prospects.[17] Between 1970 and 1993, the number of foreign medical graduates in the USA rose from 57,000 to 150,000, with India, Pakistan, and the Philippines holds major proportionate of 45%. Secondly, rich and influential Pakistanis go abroad for their treatment. Again for historical reasons, majority of them go to Britain and a minority go to other countries. The statistics about these flows are not available.

“Pakistan is facing acute scarcity of health specialists as most of them have moved abroad in search of better prospects.”

Health services related trade in terms of inflows also has been of two kinds. First, there have been a limited number of students coming to medical colleges for undergraduate studies and for post-graduate studies basically from countries in the region e.g. Bangladesh, Nepal, Iran, and Afghanistan. Some have also been coming from Middle Eastern countries and African countries. Second, medical equipment, especially machinery have been imported from other countries - not as part of services though but as goods. The statistics about these flows are not available.

5.2 Trade in health services under GATS

Since 1st January 1995, the date on which WTO came into being and its various agreements took effect, and Pakistan being the founding member and having made specific commitments in the health sector, there has been no visible change in the flow of trade in health services to or from Pakistan. Few new trends, however, have emerged and grown in this period e.g. businesses of medical transcription and telemedicine, but these trends are quite independent and cannot be attributed to GATS and Pakistan's commitments therein.

5.2.1 An analysis of Pakistan's commitments in health related services

Around 83 WTO member countries have made one or another kind of commitment in the health sector. Out of these 83 countries: 27 have made commitments in "Hospital Services"; 7 have made commitments in "Social Services"; 12 have made commitments in "Other Human Health Services"; 3 have committed in "Other" category; 36 countries have made commitments in "Medical and Dental Services"; 12 have committed in "Services Provided by Midwives, Nurses and Physiotherapists"; and 63 countries have made commitments in "Health Insurance".[18]

In case of specific commitments in health sector, Pakistan has been more liberal than neighboring South Asian countries. Bangladesh and Nepal have not made any commitments in any health related services, so they are not among 83 countries. India has made commitment only in hospital services. Unlike its neighbors, Pakistan has made commitments in both hospital services and in medical and dental services.

"In case of specific commitments in health sector, Pakistan has been more liberal than neighboring South Asian countries."

Pakistan made a number of important commitments in health related services. The main commitments are under "health and related social services" and in "Business services" sectors but there are commitments in other sectors and sub-sectors which are related to trade in health services. Following is the detail of these commitments:

a. Health and related social services

There are four sub-sectors in this group and Pakistan has made commitments only under Hospital Services (A). The classification list of services sectors and sub-sectors exclude services listed as "Medical and dental services" (h) and "Services provided by midwives, nurses, physiotherapists and para-medical personnel" (j) in sub-sector of "Professional services" (A) under "Business services" (I).

Commitments made under hospital services sub-sector means that Pakistan is committed to allow private hospitals services to be set-up in Pakistan by foreign nationals/companies. These can be in the form of:

- Construction of new hospitals by foreign companies;
- Franchises by foreign hospitals; and
- Setting-up of representative offices by foreign hospitals.

Mode 1: Cross-border supply in hospital services can mean a parent hospital in a foreign country providing diagnostic or therapeutic expertise through telemedicine or other means to its branch hospital in Pakistan. Pakistan has kept its commitments on market access and national treatment

open or "Unbound" in this mode of supply for the reasons of lack of technical feasibility. This means that although Pakistan has committed to allow foreign hospitals to be set-up or represented in Pakistan it has not defined specifically the extent of market access or treatment it will provide to foreign hospitals as opposed to local hospitals (national treatment) with reference to cross-border supply of diagnostic or therapeutic services. Thus, it can negotiate with other trading partner countries if it receives a request from them for entering into hospital business in Pakistani market. This "Unbound" status provides leeway to Pakistan for negotiations. Pakistan has not made any additional commitment in this mode.

Mode 2: Consumption abroad. There is no commitment made under this mode for market access and national treatment because commitment under this mode for hospital services does not make any sense. Pakistan can only commit to allow foreign hospital services to be available within the country for domestic consumers but it cannot commit, that domestic consumer would surely consume hospital services abroad.

Mode 3: Commercial presence. This mode is most obvious for trade in hospital services. From commitment point of view Pakistan has allowed foreign hospitals to set-up businesses on its land. Pakistan has not put any specific limitations on market access in this regard although the *General Obligations* would be applicable which in this case would mean that:

- representative offices of foreign companies (foreign hospitals service providers) will have to be incorporated with Security Exchange Commission of Pakistan and their equity shares can be majority but not more than maximum of 51%, which means that up to 49% equity shares would be of Pakistani investors. These representative offices will only undertake liaison work which in case of hospital service providers means that patients could get information from them about their parent hospital services abroad; they could register the patients and could market their parent facilities and services.
- acquisition of real estate by non-Pakistani entities and/or persons (foreign hospitals service providers) is subject to authorization on a case-by-case basis keeping into account the purpose and location of the hospital services. Through this limitation government has kept the discretionary control over giving property rights to foreign entities (foreign hospital service providers).
- the Pakistani government has put limitations on the presence of foreign staff of the foreign firm (foreign hospital service provider) interested in providing a service in Pakistan to a maximum of 50% in case of executive

(hospital administrators) and specialists (medical, surgical specialists etc.) category. In order to be sure of the expertise of such staff another condition has been put for movement of such persons to Pakistan i.e. such staff members should have been working with that particular firm (hospital) for a period not less than one year before their transfer to Pakistan. In order for not leaving any ambiguity, the terms "executives" and "specialists" are also clearly defined in the schedule. Apart from executive and specialist category, there have been no other limitations on movement to and presence of other staff categories which is a liberal approach and which in case of foreign hospital service provider in Pakistan means that whole of the para-medical or nursing staff in that facility can be foreigners.

As for the regulation of foreign hospital service providers is concerned i.e. licensing of facilities, recognition of its foreign qualified professional staff etc. Pakistan Medical and Dental Council rules, regulations and procedures would be applied.

No limitation on national treatment has been put on trade in health services under mode 3. All hospital service providers will be treated equally by law.

Mode 4: Movement of natural persons. Both under market access as well as under national treatment, the movement of foreign staff to Pakistan to provide hospital services has been kept unbound except as indicated under horizontal measures and explained above under mode 3.

b. Medical and dental services

"Medical and Dental Services" (h) are one of the services in "Professional Services" (A) under "Business Services (I) sector. Pakistan has included these professional services in its commitment schedule, which means that Pakistan has committed to make available its medical and dental services market to foreign providers. Foreign providers of medical and dental services in Pakistan can operate through different modes of supple. In each mode, Pakistan has committed to provide market access and national treatment and specified limitations for these. There is a lot of overlap between "hospital services", "medical and dental services" and "movement of natural persons" as in most of the cases three of these would be interdependent. In other words there would be a mix of modes in the supply of Medical and Dental Services.

Mode 1: Cross-border supply. Medical and dental services supply by foreign suppliers in Pakistan can take place under following three arrangements:

- foreign medical and dental experts providing diagnostic and therapeutic advice to Pakistani hospitals;
- foreign medical and dental experts providing diagnostic and therapeutic

advice to their own set-up hospitals in Pakistan; and

- foreign telemedicine company setting up a facility in Pakistan with linkages with foreign hospitals and foreign individual specialists.

Services would be supplied under this mode through modern electronic or conventional communication means.

Pakistan, for reasons of lack of technical feasibility, has not bound itself with any commitments for providing market access or offering national treatment to foreign operators.

Mode 2: Consumption abroad. This mode of supply in the context of Pakistan's commitments for market access and national treatment to foreign suppliers of medical and dental services in Pakistan does not apply so Pakistan has mentioned no limitations.

Mode 3: Commercial presence. This is most applicable mode in the supply of these services in Pakistan by foreigners. Suppliers of medical and dental services in Pakistan can have commercial presence as a medical facility of their own (hospital) or they can have an arrangement with a local hospital through which they can offer their services or these can have franchised arrangement.

In case of market access, Pakistan has mentioned;

a. As in measures applicable to all sectors; and
b. Subject to Pakistan Medical and Dental Council Regulations.

These specifications mean that in case of "a" for market access all those horizontal or general obligations would be applicable as mentioned above while discussing mode 3 supply of "Hospital Services" in Pakistan, namely;

- condition for incorporation in Pakistan;
- limitation on equity shares;
- government discretion to provide property rights for real estate acquisition; and
- limitations on the presence of foreign staff (executive and specialist categories).

And in case of "b" it means that the regulation of foreign medical and dental service providers will be in accordance with the policies, rules, regulations and procedures of Pakistan Medical and Dental Council i.e. licensing of facilities, recognition of its foreign qualified professional staff etc.

No limitation on national treatment has been put on trade in health

services under mode 3. All medical and dental service providers will be treated equally by law.

Mode 4: Movement of natural persons. Both under market access as well as under national treatment, the movement of foreign staff to Pakistan to provide medical and dental services has been kept unbound except as indicated under horizontal measures and explained above under mode 3 and in more detail in mode 3 under "Hospital Services".

Pakistan has not made any specific commitments in the following (Table-2) directly health related sectors and sub-sectors:

Table - 2: Non-Commitments in Health Services

#	Sector	Sub-sector		Health service		
1	Business services	A	Professional services	j	1	Services provided by midwives, nurses, physiotherapists and para-medical personnel
		C	Research and development services	c	2	Interdisciplinary R&D services
		F	Other business services	a	3	Advertising services
				b	4	Market research and public opinion polling services
				k	5	Placement and supply services of personnel
				m	6	Related scientific and technical consulting services
				n	7	Maintenance and repair of equipment (not including maritime vessels, aircraft or other transport equipment)
4	Distribution services	B	Wholesale trade services			
		C	Retailing services			
		D	Franchising			
5	Educational services	C	Higher educational services			
		E	Other educational services			
7	Financial services	A	All insurance and insurance related services	a	8	Life, accident and health insurance services
8	Health related and social services	B	Other human health services			

Pakistan has made commitments in many other services sectors and sub-sectors which are not directly related with health services. However, those will assume importance when Pakistan would be trading in health services. Such sectors include: Integrated Engineering Services; Computer and Related Services; Data Processing Services; Data Base Services; R&D Services on Natural Sciences; Technical Testing and Analysis Services; On-line Information and Data Base Retrieval; On-line Information and/or Data Processing; Life Insurance; Banking and other Financial Services; and Travel Agencies and Tour Operator Services. It is out of the scope of this study to analyze Pakistan's commitments in all these sectors but it is important to know about them.

5.2.2 Cross-border supply of health services:

Trade in health services in Pakistan under Mode 1

Cross-border supply of health services mean supply of different kinds of health services in country A by suppliers in country B via different means. Broad categorization of different kinds of health services which can be provided through this mode include diagnostic, therapeutic, educational, public health consultancy and medical data processing services. Means of communication used in this mode of supply range from shipment (e.g. specimens for laboratory testing) and traditional mail channels (e.g. reports for second opinion) to online interactive audiovisual systems. Integration of telecommunication systems into the practice of protecting and promoting health is now called telehealth. This system, if used for therapeutic purposes, is called telemedicine, which is a growing way of communication between countries, especially between developed countries but also increasingly between developing and developed countries. Telehealth services employ interactive audiovisual and data communication systems to provide services such as diagnosis, second opinions, laboratory testing, surveillance, consultations, transmission of access to specialized data, records, and information, and continuing education and upgrading of skills. This is now considered as the most efficient and increasingly popular mode of cross-border supply of health services and overwhelmingly dominates other traditional cross-country supply means.

Telemedicine is now being considered as an approach in developing countries to overcome the issues of inaccessibility of health care by the people because of geographical remoteness and the scarcity of doctors and specialists. Dr. Mubina Agboatwalla, a primary health care specialist in Pakistan in her article wrote about the reasons and prospects of telemedicine in

Pakistan. She wrote, "For developing countries such as Pakistan, having large remote rural areas where health facilities are inaccessible, there appears to be an ideal opportunity to invest in telemedical systems linking main tertiary health care centers with small health facilities in remote rural areas... Physicians from developing countries, like Pakistan, can freely interact and deal with complicated medical problems, in consultation with experts in State of Art Medical Centers. This would reduce the cost of transferring patients to these Medical Centers... For a country like Pakistan it would be an ideal solution to provide health care to remote rural areas. The problems encountered in providing quality health care in remote areas might well be taken care of...Patients in Pakistan will be spared the cost of traveling abroad for medical care, whereby consultation with experts round the globe could be held with local doctors. An ever expanding opportunity for Continuous Medical Education (CME) could be open for local physicians, unable to go outside the country for training. However the pre-requisite for such a setting is the development of a communication infrastructure.

Finally, in Pakistan technical hurdles like electricity failures might greatly hamper the progress of procedures such as telesurgery procedures, when the TV Screen can suddenly go blank during a surgical procedure. The applications of telemedicine are limitless and this is an excellent opportunity for physicians and patients for provision of higher quality, more accessible health care".[19]

In case of Pakistan, at present the telehealth is at a nascent stage. Efforts have just begun to promote the idea within the country in terms of linking up the rural and urban health facilities the details of which are provided below. Cross-country supplies of telehealth services are almost non-existent but Pakistan is getting prepared for it. It has developed a good IT infrastructure. Currently, internet services are available in 1350 towns and cities all over the country out of which 400 cities are on fiber-optic.[20]

There have been efforts to promote telemedicine in Pakistan (for details see Box-7), meanwhile important developments are taking place at the regional level. Bangladesh Telemedicine Association (BTA) has taken concrete steps towards organization of a telemedicine network in South Asia, called "South Asian Association of Telehealth Initiatives" (SAATHI), which will include Bangladesh, India, Sri-Lanka, Pakistan, Nepal, Bhutan, and Mal-Dives. The SAATHI may be extended to Myanmar, Thailand and other countries of the Far-East including China.[21]

Box - 7: Telemedicine in Pakistan

To promote telemedicine in Pakistan, a National Telemedicine Forum has been established as a working group of Technology Resource Mobilization Unit (TReMU) under the auspices of Federal Ministry of Science and Technology with an aim to join over hundred cities of Pakistan and provide medical benefits to maximum people across the country. Two Doctors from this forum have been sent for telemedicine training in USA by the Ministry of Science and Technology. The first meeting of this forum took place in October, 2001 in Islamabad and a National Telemedicine Conference took place in 2002. During this conference a live surgery was shown for the first time in the country from Holy Family Hospital Rawalpindi. Also, a live consultation session took place from Gilgit (remote hilly town up in the north) to Islamabad via V-SAT.[22] A U.S. and international survey report (in making) under the auspices of Telemedicine Information Exchange has two entries from Pakistan: TelMedPak and Telesonography, both are Islamabad based. Another, Star Telemedicine Solutions is Karachi based. TelMedPak is the pioneer organization, which was established few years ago as an NGO with a cause to promote telemedicine in Pakistan. It aims to link all the primary health care facilities in Pakistan with urban hospitals. Recently, Paknet (state owned and largest internet provider in the country offers services to more than 400 cities and towns), joined hands with TelMedPak to expand operation of telemedicine in other parts of the country. Both the organizations are collaborating to facilitate the people in Northern Punjab towns of Fateh Jhang, Gujar Khan, Taxila, Pinddadan Khan and Jhand through telemedicine in order to provide best possible health care facilities to the people of rural areas.[23] Likewise, Allahtuwakkal Network (ATN) Group recently joined hands with TelMedPak for the establishment of 50 telemedicine centers in rural areas in all the four provinces and AJK in Pakistan.[24]

5.2.3 Consumption of health related services in other countries: Trade in health services in Pakistan under Mode 2

There can be many forms of consumption of health related services abroad but important ones are: patients moving from country A to consume medical facilities of country B; and students moving from country A to country B for medical or allied graduate or post-graduate studies and/or trainings. For a particular country, practically, this kind of flow can be two-ways e.g. in case of Pakistan, patients/consumers and students going from Pakistan to other countries for consumption of health services and studies and at the same time patients/consumers and students from other countries coming to Pakistan for consumption of health services and studies.

Although exact figures are not available about such flows across Pakistan[a] but common observation is that there is much more outflow of patients and health sciences students from Pakistan than inflow from other countries.

So Pakistan is a net "importer" of treatment services and health related educational services of other countries albeit looking through mode 2 lens these services are bought and consumed by Pakistani patients/consumers in other countries.

From pure business point of view, Pakistan has to tilt the balance of existing flow of patients and health sciences students across its boundaries i.e. more Pakistanis consuming abroad than foreigners consuming in Pakistan to more foreigners consuming in Pakistan than Pakistanis consuming abroad, to be benefited. This requires that Pakistan should become attractive enough for foreigner patients and medical students that they decide to come here for treatment and studies like Thailand and India has done. Is it possible for Pakistan with huge Indian and Chinese markets in its vicinity? This question begs a strategic answer. One has to look at the "comparative advantage" that Pakistan can offer despite being surrounded by economic giants like China and India. Pakistan does have comparative advantage against two different sets of countries in two different ways. Pakistan can offer itself as a better country to patients and students from other predominantly Muslim countries for its cultural similarity. In this sense it will be competing with countries like Iran for patients and students from Central Asian countries, Arabian peninsular countries, Gulf States and near-east countries, Afghanistan and pre-dominantly Muslim countries in the northern Africa.[b] Unless Pakistan can uplift the standards of private health care, it will be difficult to attract patients even using this comparative advantage but facilities which have lived up to international standards are already reaping the benefits in the form of inflow of patients from Muslim countries e.g. there is a continuous flow of Saudi Arabian patients to Sharif Medical City Hospital in Lahore for kidney transplantation for low price and high quality.[25]

Another set of countries and line of comparative advantage is purely economic. How much competitive Pakistan can be with other countries in the same (low) income bracket and those in the middle income bracket, for example, South East Asia, is a major question. Developing countries do offer

> *"Pakistan can offer itself as a better country to patients and students from other predominantly Muslim countries for its cultural similarity."*

[a] Pakistan Medical and Dental Council, Federal Ministries of Health, Commerce, Labor, Export Promotion Bureau and Overseas Pakistanis Foundation have been checked in this connection but none has revealed any systematic record of such flows.

[b] For Example: The Health Minister of Gambia Dr Yankubia Gassama has hinted that Gambian patients with complicated diseases would be sent to Pakistan in future to avail health facilities of Pakistani hospitals. He said that despite the large distance between the two countries Gambia will try to send complicated patients to Pakistan instead of Europe and other countries. "We are Muslims and sharing a common cultural heritage so we will prefer Pakistan on other countries".
- The Nation, 31st January 2003.

a great differential in costs of health care. Liver transplantation, which has recently been successfully done in Pakistan, costs US $ 250,000 in the West[26] as opposed to few thousand dollars in Pakistan. In India, for example, a coronary bypass operation costs Rs. 70,000 - 100,000, compared to Rs. 1.5 - 2.0 million in Western countries.[27]

In the nutshell, Pakistan should target upper-middle class patients and students from low income countries and especially those from the Muslim countries. This strategy can be Pakistan's best bet for trade in health services in mode 2. But of course, it requires a lot of strategic thinking and preparation which many other countries have already initiated e.g. India has set up a task force to promote India as a health destination and which is already claiming that it is receiving increasing number of patients even from South Asian countries including Pakistan.[28] It is interesting to note that ongoing "Confidence Building Measures" to improve relations between India and Pakistan, India offered Pakistani children treatment in India!

5.2.4 Commercial presence of health related services in other countries: Trade in health services in Pakistan under Mode 3

From the point of view of trade in health services this is a very important mode whereby foreigners from country A can set-up health facilities in country B. From the point of view of GATS, if both the countries are WTO members and have made specific commitments for health trade under mode 3 - which majority of the member countries have made - in hospital services or medical and dental services, then it becomes obligatory for country B to provide market access to nationals and commercial entities of country A to set-up facilities in country B.

Since Pakistan has made commitments in both hospital services and in medical and dental services, other countries can come and set-up their health facilities in Pakistan. And Pakistan has to treat these facilities according to its general and specific commitments. Likewise, whichever member countries have also made such commitments, private health service providers can also open their facilities in those countries in accordance to their commitments and domestic policy and regulatory regimes but practically it will not be possible for overwhelming majority of private service providers in Pakistan for their scale and quality of services. Only few can potentially think about this proposition i.e. the likes of Aga Khan Hospital in Karachi. So Pakistan would be, for times to come, a net "importer" of foreign health services in the form of their commercial presence in Pakistan.

There can be a number of forms of commercial presence. It can be a hospital, a laboratory, a liaison office of a hospital which itself is situated in

another country, or it can be a franchise of a foreign health facility owned and run by locals.

Pakistan has open investment policy in hospital sector. Minimum foreign equity component should be US $ 0.5 million to be invested on repatriable basis and 100% foreign ownership is allowed. Despite of such liberal investment policy and as opposed to other developing countries, Pakistan does not enjoy any portfolio of foreign direct investment in hospitals. However, a multinational health insurance company, Allianz, has invested substantially in the health sector. In Pakistan currently some hospitals are represented through liaison offices, for example Cromwell hospitals of UK have liaison offices in Peshawar and Islamabad. There are also some health related franchised business e.g. Materna SA of France has franchised clinics where baby sex can be determined through Selna technology terming it as advanced family planning,[a] these clinics are situated in Rawalpindi and Lahore.

"Pakistan has open investment policy in hospital sector...and 100% foreign ownership is allowed"

5.2.5 Movement of natural persons:

Trade in health services in Pakistan under Mode 4

Movement of natural persons in case of trade in health services mean movement of health related professionals. From developing countries point of view in general, this mode of supply is most important. For many developing countries this is the only comparative advantage in terms of trade. The presence of professional work force from developing countries in rich countries and their remittances become a great source of national income in the form of foreign exchange and help to narrow the chronic balance of payment problems. From this angle, mode 4 in GATS is of special significance for developing countries. Currently, there is a lot of debate about "free movement of people" as part of free trade. Experts from developing countries argue that free movement of capital should go hand in hand with free movement of labor. Some authors have even proposed a new international treaty on free movement of people.[29]

In the context of GATS, the movement of health professionals can be either part of the mode 3 i.e. commercial presence or independent of mode 3. Example of mode 4 dependent on mode 3 is that if health service providers from country A set-up a hospital in country B, and they bring at least part of their work force with them from country A, like doctors, nurses etc. The number of (especially) professionals they can bring to country B depends on

[a] This is a controversial technology and there is a lot of criticism on these clinics by many medical professionals.

the combination of: level of commitments of country B in terms of exemptions to MFN; limitations on market access; limitations on national treatment; the investment policy, domestic regulations; and visa policies. Example of independent mode 4 supply is that health professionals from country A move to country B for jobs after having satisfied the criterions for qualifications, experience, entrance examinations etc. These jobs can be in the public sector or in private sector of country B. If these jobs are in the private sector of country B then only these are considered as part of the trade in health services but if health professionals are moving from country A to fill jobs in public sector of country B, then it is not considered as part of the trade because of Article 3 (b, c) of GATS.[a]

"With reference to GATS, generally Pakistan has a special interest in labor movement from Pakistan as a source of remittance as well as a strategy to overcome the issue of unemployment."

In the case of Pakistan, in terms of foreign investment, since it has made commitments in "hospital services" and "medical and dental services" sectors, it has to allow foreign health professionals if foreign service providers decide to invest in hospital sector or in provision of medical or dental services in Pakistan. Since Pakistan limits the number of executives and specialists to not more than 50% (horizontal commitment) so at least 50% of executives (hospital administrators) and specialists (medical and surgical experts) will have to be Pakistanis. As for non-specialist staff is concerned, i.e. para-medical and support staff, it is up to the investors if they want to bring that entire staff from abroad or want to employ from within Pakistan. To date, however, no such investment has been made so no such experience is available.

With reference to GATS, generally Pakistan has a special interest in labor movement from Pakistan as a source of remittance as well as a strategy to overcome the issue of unemployment. In an interview before leaving for WTO ministerial meeting in Cancun the Federal Commerce Minister while discussing the services sector said that Pakistan would focus (in the meeting) particularly on those areas which are related to foreign direct investment and major revenue and job generation fields. The minister said Pakistan's primary concern was that the manpower movement should be allowed so that our labor could go abroad and work.[30]

Many Pakistani health professionals, especially doctors, keep moving to other countries in search of better jobs. A large number of them also get settled in other countries. Maximum numbers of Pakistani health professionals

[a] Article 3: For the purposes of this Agreement: ...(b) "services" includes any service in any sector except services supplied in the exercise of governmental authority; (c) "a service supplied in the exercise of governmental authority" means any service which is supplied neither on a commercial basis, nor in competition with one or more service suppliers.

are in USA and UK but after the severe visa restrictions job markets in other countries are being filled including those in the Middle East and South East Asia. In the context of mode 4 of GATS, there can possibly be two scenarios for movement of Pakistani health professionals. Firstly, health professionals going abroad as part of Pakistani investment in other countries to set-up hospitals and medical services. Secondly, health professionals moving out to other countries on their own and become part of the private health services in those countries. The first possibility is more of a theory but second possibility is a big reality.

The movement of health professionals out of the country, if seen through business lens, is appreciable as a source of remittances in the form of foreign exchange. But it also needs to be seen through public health lens, in terms of unmet health care needs of the country which is sending its health professionals abroad.

"The movement of health professionals out of the country...needs to be seen through public health lens, in terms of unmet health care needs of the country which is sending its health professionals abroad."

6. Trade in health services and equity in health[a]

As explained in the section on overview of health care system in Pakistan, the state health care system is at best being able to provide curative health coverage to not more than 30% of the population. Pakistan spends relatively little on the health; has poor health indices as compared to countries at the same income level and disparities in health are marked.

Box - 8: Poverty and Health Linkages

Although there are few equity-in-health studies available in Pakistan, yet the mere fact that poverty has been on the rise all through the decade of 1990s, different estimates provide a range from 32-40% of the population in the country living under absolute poverty line, that about 65-70% of the population lives in rural areas where health care system is most needed and least available; and that 80-90% of the poorest people in the country live in rural areas are indicative of the location and seriousness of the problems. There is also a serious urban bias in the distribution of health care. Around 70% population rely on private health sector. With this scenario, what should be the priorities of the government in the health sector?

For conducting research on the issue, various meetings were held with senior policy makers in both Federal Ministries of Health and Commerce and it was found out that no such analysis on implications of GATS exist. During these meetings it was found that the level of understanding about the subject was quite low. There was no single government document found, which specifically looks at this issue. There is no body in the Federal Ministry of Health exclusively in-charge for this subject and in Ministry of Commerce the

[a] Equity in health: Disparities or inequalities in health between rich and poor, men and women, urban and rural, old and young, and white and black are well established. These inequalities, if seen through the perspective of fairness, are called inequities. Disparities in health outcomes are the most important dimension of the health equity. To address inequity in health is, and should be, the first and for-most objective of a national health policy. This objective is embedded in the principal of social justice. Achieving equity in health in a country is not just dependent on its health care system though it is one of the most important components of the overall strategy. Equity in access to health care services is crucial to achieve equity in health. In most cases, inequalities in health are unfair, and most importantly, these are avoidable. Addressing inequity in health, especially inequity in access to health care services, require deliberate and targeted policies and action. The policies should be mindful of determinants of inequity, well connected with other important national policies and have their objectives and priorities clearly spelled out.

subject is not given any special importance. In this regard Pakistan Institute of Development Economics (PIDE) was also not different from others, which is a leading research institution on economic issues in the country with impressive research output. Although they have done some work on GATS agreement but health services has not been picked up as a special area of inquiry. In Pakistan there also exists Pakistan Hospital Association. The office bearers of the association were also enquired upon about their perceptions about GATS and trade in health services in Pakistan and how it is going to affect their businesses in times to come. They have also not really looked into the subject.

In September 2003, Dr. Nabeel Akram of Department of Community Health Sciences at Aga Khan University has completed a study on "GATS and Equity in Health Services in Pakistan: Opportunities, Concerns and Limitations" as a thesis for his MSc in Health Policy & Management.[31] The study has attempted to analyze the situation of trade in health services from a perspective of health policy goals and objectives, further the overall goals of the health policy in terms of equity? Or what will be the effect of trade in health services in Pakistan on equity of health services? He has adapted and applied benchmarks of fairness[a32] to study the implications of issues related to equity in health with the introduction of GATS and enhanced trade in health services. Using five equity related benchmarks of fairness in health, namely: inter-sectoral public health; financial barriers to equitable access; non-financial barriers to access; comprehensiveness of benefits and tiering; and equitable financing. He has tried to assess various facets of trade in health services in 4 modes of supply by scoring them on a scale (-5 to +5, 0 representing a status-quo). He has used double scoring criteria by using performance scale and evidence scale. Along with this numerical scale, direct and indirect evidence scales he has also conducted interviews with 15 key informants: policy makers from both ministries of commerce and health; policy implementers; and people from relevant NGOs.

In this study, "lack of data relevant to trade in health services in Pakistan came up as the most striking limitation to comment on each benchmark criteria. None of the criteria in any mode of service could indicate through direct or indirect evidence that it may improve equity in any or all related variables. Key informant interviews conducted for an in-depth inquiry

[a] Fairness has been described as a many-sided concept, broader than the concept of equity. Fairness includes equity in health outcomes, in access to all forms of care and in financing. Fairness also includes efficiency in management and allocation, since when resources are constrained their inefficient use means that some needs would not be met that could have been. For the public to have influence over health care, fairness must also include accountability. Finally, fairness also includes appropriate forms of patient and provider autonomy.

revealed that there is considerable lack of knowledge about GATS and interviewees were generally unable to comment on equity in health in relation to GATS. There has also been lack of reliable, comprehensive, and internationally comparable data in Pakistan to understand the implications of trade in health services on equity in health system. It might be too early to arrive at firm conclusions regarding the impact of GATS on equity in health services in the country. Research in the country must be encouraged to provide information needed to strengthen the development of policies. There is also need for advocacy and awareness rising within the health sector, and for coordination between different sectors, in order to mitigate the potential negative impact of the liberalization of health services on vulnerable groups."

"Wealthy classes would benefit maximally from enhanced trade in health services in Pakistan"

As mentioned above, lack of specific data is a major problem in order to infer conclusions about the implications of liberalization of trade in health services in Pakistan, however, some observations can be made from the perspective of equity in health. First of all, since trade in health services means activities in private health sector, one has to analyze the private health sector in Pakistan.

Only wealthy classes use private health facilities by choice. Middle classes use private facilities because they do not get reliable care from the public health sector and poor people use private facilities because they don't have any option in case of serious illnesses, although they cannot afford it. Wealthy classes would benefit maximally from enhanced trade in health services in Pakistan, others would be affected in different ways depending upon the specific service and mode of supply.

In this context, one assumes that trade and health services under GATS would not directly effect the public health sector under "governmental authority" using restrictive interpretation of Article 3.b and c, unlike many critics of the GATS. But still, if we factor-in the growing wave of "autonomy" of public sector hospitals in Pakistan, we are not sure, under which category these hospitals would fall.[a] Would these be considered as "services supplied by the government on noncommercial basis and not in competition with other service suppliers" or these would be considered as independent (autonomous) entities which are already competing with private health sector in terms of attracting patients and health professionals. These remain open to interpretation, and the implication on equity needs to be analyzed as

[a] As a first step towards implementation of enforced Punjab Medical and Health Institutions Rules, 2002, Punjab government has granted financial autonomy to 11 autonomous teaching hospitals in the province. The notification to this effect was issued by the Punjab Health Department. From now onwards, these autonomous health institutions would be free to spend from their respective earnings according to their requirements without any interference on the part of Health Department. - *The Nation, 21 July, 2002*

these hospitals also act as referral hospitals for the primary and secondary public sector health facilities.

Mode 1: Cross-border Supply: If we only take the example of telehealth / telemedicine in this mode, it is obvious that for poor Pakistanis and for those living in remote areas, telemedicine facility, whereby diagnostic and therapeutic advice can be sought from experts sitting in other countries, would remain unaffordable and inaccessible. However, as government is joining hands with TelMedPak to link-up rural health facilities with urban hospitals, this might be helpful to rural poor and sick to get specialized help, but it will have to be through public sector. Telemedicine as a commercial venture would be irrelevant to rural poor in Pakistan. If private Pakistani doctors set up telemedicine facility through which they can provide advice to doctors and patients in other countries, then the only beneficiaries of such ventures would be those businesses.

Mode 2: Consumption abroad: Only wealthy patients and students who can afford medical and allied studies in other countries would benefit. Inflow of patients and students from other countries to Pakistani hospitals and educational institutions would benefit the local providers only.

Mode 3: Commercial presence: If foreign providers set-up hospitals or other arrangements to provide medical or dental services in Pakistan, it will enlarge the choices for wealthy patients. For poor they would remain inaccessible. However there is another implication. Since, Pakistan has limited the presence of executive and specialized staff to not more than 50% in its horizontal commitments, so if a foreign company set-up a hospital in Pakistan, it will have to employ at least 50% of the specialized staff from Pakistan, which will be good from job generation point of view but it will also have a crowding-out effect i.e. specialized doctors, which are already not enough in the public sector, would move from the public sector to private sector and specialized care would further be squeezed for the poor patients who still rely on government health care system. Same would be the effect when Pakistanis set-up hospitals in other countries.

Mode 4: Movement of health professionals: Although this is Pakistan's main interest in GATS, in case of health services, however, more health professionals moving out of the country would mean less available in Pakistan. To optimally benefit from this mode in health services, a strategic policy is required whereby we produce more health professionals so that after meeting our own needs, we should be able to export them and earn foreign exchange, which should be spent on improving health care system in Pakistan, otherwise it would be a simple brain-drain and net financial loss. Pakistan will loose financially because medical education is highly subsidized

(up to 90%). There are some positive indications about government's thinking on these lines. In this respect the steps taken by Ministry of Labor and Manpower is applaud able to produce more nurses by introducing evening classes in nursing schools because there is a huge demand for nurses in international market. Although, it will take a long time to first meet our own needs for nurses as Pakistan is a unique country with more doctors in the country than nurses.

> *"Pakistan is a unique country with more doctors in the country than nurses."*

3. Conclusion

Within just 11 years of its adoption, the GATS has become one of the most debatable elements of the international trading system, as it presupposes benefits from the deregulation of trade in services and to open up all service sectors to international competition. More and more countries are becoming aware of the threat posed by the scope of the GATS agreement, and there is a growing call for governments to defend essential services from the GATS liberalization agenda. As GATS is not designed to improve health services, social equity or accessibility, its objective is unfettered and unregulated trade and commercialization.

From the point of view of developing countries and their inadequate health systems to meet the health care needs of their population, GATS and trade in health services pose more challenges than offer opportunities. The case of Pakistan is no exception in this sense. Instead of strengthening the institutions of health care by introducing the proper consumer protection, competition and regulatory structures, on the contrary, has liberalized its health services more as compared to its counterparts in South Asia.

The study argues that, if at all Pakistan wants to reap benefit under GATS, mode 4 (movement of health professionals) with all its implications has more competitiveness than mode 1 (cross-border supply), mode 2 (consumption abroad) and mode 3 (commercial presence). But the overall agenda of GATS will lead the health care system through privatization and commercialization towards an environment where only those who can afford to pay will get the best care.

GATS will see the entrenchment of privatization of health services. Corporate ownership of health services will increase, resulting in the gradual abolition of the publicly funded health care system. Cost will become the most relevant factor, restricting rather than enlarging consumer's choices of health services in a country where most of the population is poor and marginalized.

In the context of GATS and Pakistan's commitments therein, the major question to be answered is that how liberalization in trade in health services in Pakistan would affect the already inadequate and iniquitous health care system in the country. It is, and should be, an unavoidable question for the policy makers in Pakistan and to begin with require a serious analysis of pros and cons of trade liberalization in health services.

"...developing countries and their inadequate health systems to meet the health care needs of their populations, GATS and trade in health services pose more challenges than offer opportunities."

Appendix: Pakistan's Schedule of Commitments in GATS[a]

Modes of supply: 1) Cross-border supply 2) Consumption abroad 3) Commercial presence 4) Presence of natural persons			
Sector or subsector	**Limitations on market access**	**Limitations on national treatment**	**Additional commitments**
I. HORIZONTAL COMMITMENTS			
ALL SECTORS INCLUDED IN THIS SCHEDULE	3) i) Except in the case of representative offices where specifically provided for in this Schedule, commitments under 'commercial presence' are subject to incorporation in Pakistan with maximum foreign equity participation of fifty one per cent unless a different percentage is inscribed against a particular sector or subsector ii) All expenses of representative offices where specifically provided for in this Schedule, shall be met by remittances from abroad. Such offices shall restrict their activities to the undertaking of liaison work or of representing the interest of the parent company abroad.	3) Acquisition of real estate by non-Pakistani entities and/or persons is subject to authorization on a case-by-case basis keeping into account the purpose and location of the undertaking	
	4) Unbound, except for measures concerning the entry or temporary stay of natural persons up to a maximum of fifty per cent in superior categories (namely, Executives and Specialists) in an undertaking. These natural persons shall have been employed by juridical persons of another Member for a period of not less than one year prior to the date of application for entry into Pakistan, and shall be transferred to render services to the juridical person in Pakistan.		

[a] WTO Document Code GATS/SC/67

Modes of supply: 1) Cross-border supply 2) Consumption abroad 3) Commercial presence 4) Presence of natural persons			
Sector or subsector	**Limitations on market access**	**Limitations on national treatment**	**Additional commitments**
	i) **Executives** are: persons within an organization who primarily direct the management of the organization or establish goals and policies for the organization or a major component or function of the organization, exercise wide latitude in decision-making, and receive only general supervision or direction from higher level executives, or the Board of Directors.		
	ii) **Specialists** are: persons within the organization who possess knowledge at an advanced level of expertise and who possess proprietary knowledge of the organization's product, service, research equipment, techniques and management		
II. SECTOR-SPECIFIC COMMITMENTS			
1. BUSINESS SERVICES Services incidental to agriculture and forestry (excluding fishing and hunting) (CPC No. 881+882)	1)Unbound 2)Unbound* 3)None 4)Unbound except as indicated under horizontal measures	1)Unbound 2)Unbound* 3)None 4)Unbound except as indicated under horizontal measures	
Services incidental to mining (CPC No. 883+5115)	1)Unbound 2)Unbound* 3)None 4)Unbound except as indicated under horizontal measures	1)Unbound 2)Unbound* 3)None 4)Unbound except as indicated under horizontal measures	

*Unbound due to lack of technical feasibility.

Modes of supply: 1) Cross-border supply 2) Consumption abroad 3) Commercial presence 4) Presence of natural persons			
Sector or subsector	**Limitations on market access**	**Limitations on national treatment**	**Additional commitments**
Engineering services for building infrastructures: harbours, dams, hydal power, and airports, only (CPC No. 8672)	1)Unbound 2)Unbound* 3)i)Maximum of 40 per cent foreign shareholding in engineering consultancy companies; ii)Subject to partnership and/or joint venture with Pakistani engineers or engineering companies. 4)Unbound except as indicated under horizontal measures	1)Unbound 2)Unbound* 3)None 4)Unbound	
Integrated engineering services (CPC No. 8673)	1)Unbound 2)Unbound*	1)Unbound 2)Unbound*	
	3)i)Maximum of 40 per cent foreign shareholding in engineering consultancy companies; ii)Subject to partnership and/or joint venture with Pakistani engineers or engineering companies. 4)Unbound except as indicated under horizontal measures	3)None 4)Unbound	
<u>Computer and Related Services</u>			
Consultancy services related to the installation of computer hardware (CPC No. 841)	1)Unbound 2)Unbound 3)None 4)Unbound except as indicated under horizontal measures	1)Unbound 2)Unbound 3)None 4)Unbound except as indicated under horizontal measures	
Software implementation services (CPC No. 842)	1)Unbound 2)None 3)None 4)Unbound except as indicated under horizontal measures	1)Unbound 2)None 3)None 4)Unbound except as indicated under horizontal measures	

Modes of supply: 1) Cross-border supply 2) Consumption abroad 3) Commercial presence 4) Presence of natural persons			
Sector or subsector	**Limitations on market access**	**Limitations on national treatment**	**Additional commitments**
Data processing services (CPC No. 843)	1)Unbound 2)None 3)None 4)Unbound except as indicated under horizontal measures	1)Unbound 2)None 3)None 4)Unbound except as indicated under horizontal measures	
Data base services (CPC No. 844)	1)Unbound 2)None 3)None 4)Unbound except as indicated under horizontal measures	1)Unbound 2)None 3)None 4)Unbound except as indicated under horizontal measures	
R&D services on natural sciences (CPC No. 851)	1)Unbound 2)None 3)None 4)Unbound except as indicated under horizontal measures	1)Unbound 2)None 3)None 4)Unbound except as indicated under horizontal measures	
Technical testing and analysis services (CPC No. 8676)	1)Unbound* 2)None 3)None 4)Unbound except as indicated under horizontal measures	1)Unbound* 2)None 3)None 4)Unbound except as indicated under horizontal measures	
COMMUNICATION SERVICES C.Telecommunication Services			
On-line information and data base retrieval (CPC No. 7523)	1)None 2)Unbound 3)a)As in measures applicable to all sectors b)Subject to use of Pakistan Telecommunication Corporation network 4)Unbound except as indicated under horizontal measures	1)None 2)Unbound 3)None 4)Unbound except as indicated under horizontal measures	

*Unbound due to lack of technical feasibility.

Modes of supply: 1) Cross-border supply 2) Consumption abroad 3) Commercial presence 4) Presence of natural persons			
Sector or subsector	**Limitations on market access**	**Limitations on national treatment**	**Additional commitments**
On-line information and/or data processing (CPC No. 843)	1)Unbound 2)Unbound 3)a)As in measures applicable to all sectors b)Subject to use of Pakistan Telecommunication Corporation network 4)Unbound except as indicated under horizontal measures	1)Unbound 2)Unbound 3)None 4)Unbound except as indicated under horizontal measures	
CONSTRUCTION AND RELATED ENGINEERING SERVICES			
Construction work for civil engineering for bridges, elevated highways, tunnels and subways (CPC No. 5132)	1)Unbound* 2)Unbound* 3)i)As in measures applicable to all sectors; ii)Subject to partnership and/or joint venture with Pakistani engineers or engineering companies. 4)Unbound except as indicated under horizontal measures	1)Unbound* 2)Unbound* 3)None 4)Unbound	
Construction work for civil engineering for waterways, harbours, dams and other waterworks (CPC No. 5133)	1)Unbound* 2)Unbound* 3)i)As in measures applicable to all sectors; ii)Subject to partnership and/or joint venture with Pakistani engineers or engineering companies. 4)Unbound except as indicated under horizontal measures	1)Unbound* 2)Unbound* 3)None 4)Unbound	

*Unbound due to lack of technical feasibility.

Modes of supply: 1) Cross-border supply 2) Consumption abroad 3) Commercial presence 4) Presence of natural persons			
Sector or subsector	**Limitations on market access**	**Limitations on national treatment**	**Additional commitments**
FINANCIAL SERVICES A.Insurance and insurance-related services			
Insurance: Life insurance (CPC No. 81211)	1)Unbound 2)Unbound 3)Maximum of 25 per cent of foreign shareholding in existing life insurance companies 4)Unbound except as indicated under horizontal measures	1)Unbound 2)Unbound 3)Unbound 4)Unbound except as indicated under horizontal measures	
Re-insurance services and retrocession (CPC No. 81299)	1)Unbound 2)None 3)Unbound 4)Unbound	1)Unbound 2)None 3)Unbound 4)Unbound	
Services auxiliary to insurance (including broking and agency services) (CPC No. 8140)	1)Unbound 2)None 3)Representative office only 4)Unbound except as indicated under horizontal measures	1)Unbound 2)None 3)Unbound 4)Unbound	
B.Banking and other financial services (excluding insurance) The following:			
1)Acceptance of deposits of money and other repayable funds from the public	1)Unbound 2)Unbound	1)Unbound 2)Unbound	

Modes of supply: 1) Cross-border supply 2) Consumption abroad 3) Commercial presence 4) Presence of natural persons			
Sector or subsector	**Limitations on market access**	**Limitations on national treatment**	**Additional commitments**
2)Negotiating of loans and advances for the purpose of financing trade, commerce and fixed investments 3)Factoring 4)Payments, money collection and transmission services 5)Guarantees and commitments 6)Trading for own account or for account of customers, on an exchange or an over-the-counter market, the following: i)cheques and other bills of exchange; ii)foreign exchange; iii)forward exchange rate agreements;	3)Subject to economic needs test, the Central Bank may grant licences to foreign banks to undertake permissible banking activities through establishment of locally incorporated subsidiaries with a maximum shareholding of the bank not exceeding 30 per cent of the total paid-up capital of the subsidiary. Prior permission of the Central Bank is required by any person for having beneficial ownership of shares of a banking company in excess of 4 per cent of paid-up capital of the banking company. 4)Unbound except as indicated under horizontal measures	3)Unbound 4)Unbound except as indicated under horizontal measures	

Modes of supply: 1) Cross-border supply 2) Consumption abroad 3) Commercial presence 4) Presence of natural persons			
Sector or subsector	**Limitations on market access**	**Limitations on national treatment**	**Additional commitments**
iv)approved securities; v)other negotiable instruments. 7)Participation in issues and underwriting of all kinds of securities and provision of services related to such issues 8)Money broking 9)Customers' fund management 10)Financial and investment advisory services			
Participation in issuance of securities including underwriting and provision of services relating to such issues only (CPC No. 8132) HEALTH AND RELATED SOCIAL SERVICES <u>Hospital services</u> (CPC No. 9311)	1)Unbound 2)Unbound 3)a)As in measures applicable to all sectors b)subject to membership of local stock exchange 4)Unbound except as indicated under horizontal measures 1)Unbound* 2)None	1)Unbound 2)Unbound 3)None 4)Unbound except as indicated under horizontal measures 1)Unbound* 2)None	

Modes of supply: 1) Cross-border supply 2) Consumption abroad 3) Commercial presence 4) Presence of natural persons			
Sector or subsector	**Limitations on market access**	**Limitations on national treatment**	**Additional commitments**
	3)a)As in measures applicable to all sectors b)Subject to Pakistan Medical and Dental Council Regulations 4)Unbound except as indicated under horizontal measures	3)None 4)Unbound except as indicated under horizontal measures	
Medical and dental services (CPC No. 9312)	1)Unbound* 2)None 3)a)As in measures applicable to all sectors b)Subject to Pakistan Medical and Dental Council Regulations 4)Unbound except as indicated under horizontal measures	1)Unbound* 2)None 3)None 4)Unbound except as indicated under horizontal measures	
TOURISM AND TRAVEL RELATED SERVICES A.Hotels and restaurants (including catering) (CPC No. 614-643) B.Travel agencies and tour operator services (CPC No. 7471)	1)Unbound* 2)Unbound 3)None 4)Unbound except as indicated under horizontal measures 1)Unbound 2)Unbound 3)None 4)Unbound except as indicated under horizontal measures	1)Unbound* 2)Unbound 3)None 4)Unbound except as indicated under horizontal measures 1)Unbound 2)Unbound 3)None 4)Unbound except as indicated under horizontal measures	

*Unbound due to lack of technical feasibility.

References and Endnotes

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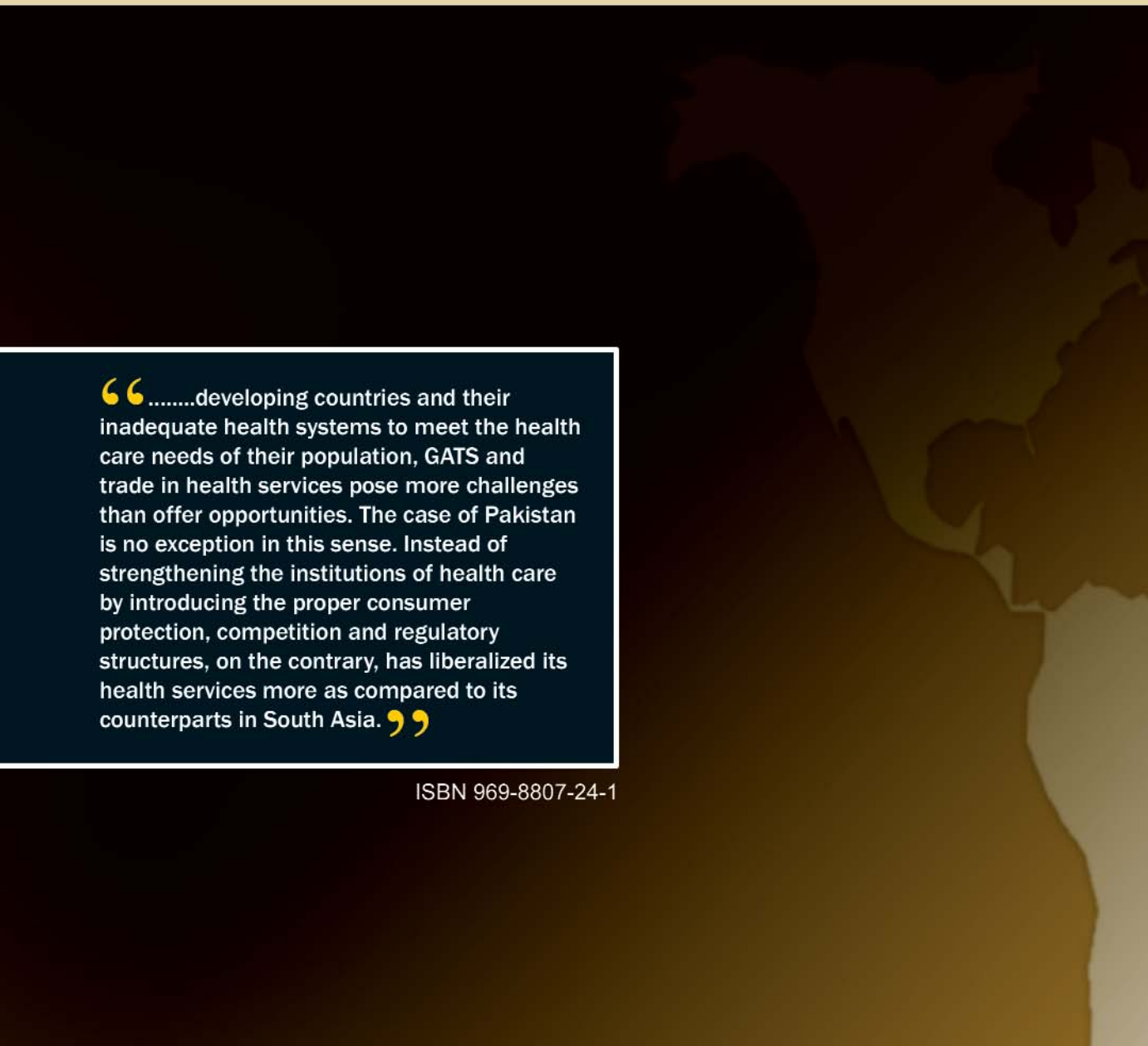
About TheNetwork

TheNetwork was founded in 1992 as a non-governmental organization with focus on medicines and public health, later expanded its attention to consumer protection in general, governance and citizens' access to justice. Over the years, the organization has emerged as an effective advocacy group, working at the local, national and international levels. TheNetwork activities include public policy advocacy, building of informed opinion, action-oriented research and publications. Its programmes are aimed at influencing public policies including legislation in keeping with the needs, rights and aspirations of citizens-consumers on a range of key issues. A Consumer Complaint Cell in the organization is dedicated to addressing people's complaints against public and private bodies/services including necessary legal guidance and support. TheNetwork enjoys a robust track record in compiling, analyzing and disseminating information, mobilizing action around key public policy issues and promoting citizens-consumers rights and interests as part of the civil society struggle in Pakistan. For further information including membership of TheNetwork contact:
+92-51-2261085 or
main@thenetwork.org.pk

TheNetwork
for Consumer Protection

40-A Ramzan Plaza, G-9 Markaz,
Islamabad - Pakistan, P.O.Box 2563
Tel: +92-51-2261085 Fax: +92-51-2262495
e-mail: main@thenetwork.org.pk
website: www.thenetwork.org.pk



"……..developing countries and their inadequate health systems to meet the health care needs of their population, GATS and trade in health services pose more challenges than offer opportunities. The case of Pakistan is no exception in this sense. Instead of strengthening the institutions of health care by introducing the proper consumer protection, competition and regulatory structures, on the contrary, has liberalized its health services more as compared to its counterparts in South Asia."

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