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# Commercial Presence in the Hospital Sector under GATS: A Case Study of India*

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*The General Agreement on Trade in Services (GATS) is the first multilateral agreement under the World Trade Organisation (WTO) relating to trade in services. India is a member of WTO and a signatory to GATS. India is also the only country in the South-East Asia Region which has in its schedule of specific commitments included Hospital Services. This paper looks closely at the implications of GATS for India under the mode of supply called commercial presence. Specifically, this research attempts to understand whether foreign investment in the hospital sector is going to be consistent with the health sector goals of the country, in terms of access, availability and affordability of quality health care.*

***Keywords: GATS, health sector, India***

## 1. INTRODUCTION

The General Agreement on Trade in Services (GATS) was signed in 1994 and was the first multilateral agreement under the World Trade Organization (WTO) relating to trade in services. WTO itself embodies the results of the Uruguay Round of Negotiations on trade. A new comprehensive WTO round was scheduled for 2000, but was launched only after the WTO Doha Ministerial Conference in November 2001. The new negotiations centered on the comprehensive agreement covering all government measures that affect services.

WTO trade agreements seek to 1) promote trade liberalization by removal of barriers like tariffs and subsidies as much as possible; 2) increase liberalization by the mechanism of negotiations between member countries and 3) provide dispute settlement mechanisms to resolve problems. These broad goals are therefore also applicable to GATS.

Specifically, GATS applies to four modes of supply of services: 1) cross border trade, 2) consumption abroad, 3) commercial presence and 4) movement of natural persons. Health sector is one of the 12 sectors listed in GATS. Two basic principles underlie GATS: the "MFN" or most favoured nation principle and the "national treatment" principle. The first requires any GATS member country that grants favourable treatment to another country, to grant the same treatment to all other GATS signatories. National treatment requires that foreign companies present on the soil of a country that is a signatory to GATS, be given the same treatment as domestic companies. GATS operates via "commitments", which are legally binding.

The views on both trade liberalization as well as liberalization in the services sector remain divided. Some believe that there are benefits of liberalising trade in services, and that goods trade liberalisation in the absence of service liberalisation could result in negative effective protection for goods (Hoekman and Djankov 1997, Mattoo 2000). Others view it as the brainchild of big businesses to protect their interests, with serious implications for

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developing countries, public services and even democracy (Sinclair 2000). The new negotiations launched in March 2000 aimed to broaden the scope of current commitments and seemed to particularly divide opinion on the role of government services; these negotiations have given rise to concerns that the agreement may limit the right of governments to regulate services and is likely to be a threat in areas like public health.[1]

India is a member of WTO and a signatory to GATS. India is also the only country in the South-East Asia Region which has in its schedule of specific commitments included Hospital Services in the first round of negotiations. It states that hospital services can be set up through incorporation with a foreign equity ceiling of 51 percent. There is no limitation on national treatment, meaning thereby that such a hospital would get the same treatment as a hospital set up by an Indian company.

India has submitted an "initial request" on the medical, dental, and health services to specific countries in the mandated on-going negotiations. The requests have been made to EC, US, Japan and Canada (mode 1 and mode 4); Far East countries (all four modes); West Asia and certain African countries (all four modes).[2] However, there has not been much discussion on how opening up might affect the health services in the country. The view from the industry sector seems to be positive and organisations like CII (Confederation of Indian Industry) are of the opinion that India can only gain by opening up the healthcare sector to global forces; in fact, the industry view seems to be that mode 3 is an important mode if checks and balances are put in place (Viswanathan 2003). Some others argue that developing countries like India should take a more pro-active role in negotiations to ensure that the new rules and regulations actually work towards the benefit of the country (Mattoo 2000). At the same time, sceptics feel that GATS and the new negotiations are highly unlikely to yield any benefits whatsoever to developing countries like India, and as mentioned above, this view treats GATS as a threat to democracy and public services.[3]

An important issue that reflects somewhat the unequal status of developed and developing countries pertains to qualification and licensing requirements, and the regulations of professional bodies as barriers for movement of personnel. In the context of FDI, this would mean recognising qualifications of foreign doctors to practice in the domestic hospitals. The situation is not symmetric for India, since most of the investment is from the west, and India does recognize the medical qualifications of these nations. The issue is serious when Indian healthcare personnel, whose qualifications are not recognised in these countries, accompany Indian investment. Mutual Recognition Agreements (MRAs) are allowed provided recognition of qualifications is not used as a means of discrimination and other countries have the opportunity to accede or demonstrate equivalence (Mattoo 2000).

Another issue that is related to indirectly to FDI is the lack of portability of health insurance: if FDI encourages medical tourism and attracts foreigners due to quality assurance, lack of insurance is going to be a barrier to consumption abroad. This is an aspect that needs further attention and stepped up negotiations in the current system. Within domestic policies that may affect the outcome of GATS for India, privatisation of health insurance is an important one, which in conjunction with GATS, is likely to have far reaching consequences for the health sector in India.

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[1] See, www.wdm.org.uk/cambriefs/gatshealth.pdf

[2] Business Line July 03, 2002.

[3] See, www.peopleandplanet.org/ tradejustice/briefing.gats.php

With this background in mind, this study aims to analyse the implications of opening up the hospital sector for foreign equity participation under GATS, and increased foreign investment under it. It is critical that health planners understand the full implications of such agreements, so that they can plan ahead to minimise the costs, if any, of such a commitment. Of all the four modes of supply under GATS, the "commercial presence" mode can have the most far-reaching implications for the health sector in terms of both demand for and supply of health goods and services.

The proposed study is the first of its kind in India, to the extent that the previous studies did not actually study the specific collaboration cases that now exist under this mode. A series of studies were commissioned by the WHO in 1997 to look into the implications of GATS for countries of the region. Before this, there were status papers for the region prepared by consultants for the WHO/SEARO (WTO 1996). The first study on India was commissioned by the WHO/SEARO (Gupta *et al.* 1998). While exploratory in nature, it is to-date the only research study that has attempted to look at the implications of GATS and the four modes in relation to the health sector of India. Though the study was initiated more than two years ago - when the GATS commitment from countries were still few - India was one of the few countries that had indicated a commitment to open up the hospital sector for foreign investment. Thus, the results from this exploratory study are relevant, and we briefly mention a few of the important findings of this study below.

The study indicated that there could be three reasons for engaging in trade in health services of any type: 1) to earn foreign exchange, 2) to improve the health services available in the country and 3) to enhance the objective of global free trade. Keeping these objectives in mind, the three areas of potential growth for India were identified as: 1) medical tourism, 2) foreign commercial presence and 3) exchange of health personnel. The second growth area - foreign commercial presence - was seen as an area that fulfilled all the three objectives. The study, however, pointed out two important caveats: first, that care needed to be exercised to ensure that obsolete technology did not come in through this mode to the country, and second, that no glut was created by an over-supply of health services. The study concluded that as far as foreign commercial presence in the hospital sector is concerned, this mode of trade might be encouraged by India, along with appropriate safeguards, to ensure the prevention of unfair practices by both domestic and foreign establishments.

At the Inter-regional Meeting on Health and Trade held in Washington D.C. in November 1999, it was emphasised that there is a need for further research to 1) analyse the impact of multilateral trade agreements on the health status of the population, 2) study the respective roles of each mode of trade, and 3) conduct country situation analyses (WHO 1999). The latter was considered especially important to "inform trade negotiations so that potential health gains are realised and adverse effects are mitigated." Research was also needed "to obtain data that will further an understanding of dynamic competitiveness in the health sector" for countries that are contemplating commitments under any of these modes. This study is an outcome of these deliberations.

Specifically, the following questions were sought to be addressed in the study:

1) Are the foreign investments in hospitals/diagnostic centers going to provide *additional* areas of service, which are in short supply, or are these going to replace the existing services? In other words, would the overall availability of similar services increase in the medium to long term?

2) What are the implications in terms of efficiency of opening up the hospital sector in India? Would the increasing presence of these companies improve the quality of similar services provided currently in India? What will be the effect on prices of these services?

3) What are the implications in terms of equity? Would the availability of these services lead to improved access and availability at reasonable prices to *all* sections of society, or to a restricted section only? If it is the latter, will it be at the cost of *reducing* the quality of services available to the rest of the population?

The study was based on a field survey of hospitals with and without foreign equity. This was supplemented by a survey of consumers of services provided by such hospitals. To understand the macro impacts of liberal foreign investment policy in the hospital sector (partly a consequence of the GATS commitments), an analysis of trend in foreign direct investment in hospitals and diagnostic centers is carried out. The study of foreign investment approvals in this sector was necessary to identify the foreign hospitals that could be covered in the field survey.

Needless to say that the answers to the three questions listed above would provide useful input to the formulation of policy on foreign investment in hospitals and India's negotiating strategy in the current round of GATS. An understanding of the impact that entry of foreign direct investment has on availability of and access to health services would enable a more informed debate on whether the country stands to gain from increased liberalisation of trade in health services (Chanda 2003; Dharmadhikary 2003).

The rest of the paper is organised as follows. Section 2 describes the field investigation method used in the study. Section 3 presents an analysis of foreign collaboration approvals in the health sector in India between 1991 and 2002. Section 4 presents the results from the survey of foreign collaboration and domestic hospitals and Section 5 presents the results from the consumer survey. Section 6 is devoted to requests and offers of India under GATS for the health services particularly hospital services. An attempt is made to relate this discussion to the findings in the previous sections. Finally, in Section 7 we discuss the implications and conclusions of the study.

## 2. FIELD INVESTIGATION METHOD

For this study, information was collected using field survey from three groups: hospitals with foreign collaboration (hereafter, FC hospitals or foreign hospitals), domestic hospitals that are deemed to be similar to these FC hospitals, and consumers. The last two categories – domestic hospitals and consumers – are the ones directly affected by the presence of foreign investors in the hospital sector.

It should be mentioned here that there is considerable heterogeneity among domestic hospitals in India in terms of the prices charged and the quality of services provided. At one end, there are government hospitals, especially those in small town, and at the other end there are large corporate hospitals. Clearly, it is the latter category which is relevant to compare with the foreign hospitals. Accordingly, this category of hospitals was covered in the survey.

Three separate questionnaires were designed for the purpose of collecting information from these three groups. Information was gathered from the foreign and private hospitals on the following issues, and in all these questions, the similarities and dissimilarities between the two kinds of hospitals were sought to be highlighted:

1) nature of the agreement/collaboration
2) kind of services that are being offered: general or specialty or super specialty
3) technology transfer by foreign collaborators
4) terms and conditions of contracts drawn up between management and specialised staff, recruitment procedures and other personnel issues.

5) profile and origin (in terms of previous employment) of personnel - doctors, nurses, technicians, etc.
6) profile of consumers who visit these facilities: use of facilities by foreign patients
7) price and tariff structure of major services provided
8) source of equipment, prices and duties paid
9) source of drugs, prices and duties paid
10) tax implications: exemptions or special tax concessions
11) whether there are restrictions on remittances
12) links with current and future insurance companies
13) problems, suggestions and views on foreign investment in the health sector: overall views of hospital management and administration, especially on what they feel about benefits of opening up more such facilities, presence of competitors, need in India of such hospitals, effect of opening up the hospital sector on prices, accessibility and availability of services, and quality

Apart from the investment section, the questionnaires were quite similar between the foreign and domestic hospitals.

In the consumer questionnaire the aim was to get a feedback from the users of facilities as to what they think are important criteria for choosing a particular facility over others. In the analysis, four issues were kept in mind: price or affordability, accessibility, availability and quality. The aim was to interview those consumers who have used the FC hospitals, as well as those who have used similar domestic hospitals.

As envisaged at the beginning of the research project, the methodology to be adopted for the study involved the following steps:

1) drawing up a final updated list of all FC hospitals
2) collecting all contact information of these hospitals, either from existing sources or from indirect enquiry like telephone listing or contacting other existing hospitals
3) mailing out the questionnaires to these companies along with a covering letter requesting date of interview
4) meeting the concerned officials in these hospitals
5) drawing up a list of possible domestic hospitals to interview
6) repeating steps 2)-4) above for these domestic hospitals
7) conduct surveys among consumers who have used the facilities of these FC and domestic hospitals simultaneously

Since it was physically and logistically impossible to do a complete survey of all the listed hospitals and domestic corporate hospitals, it was planned that a sample of FC hospital and domestic corporate hospitals from the metros and some major cities would be covered in the survey. The survey was carried out in 2001 and for this purpose the list of FCs approved till May 2001 was prepared.[4]

The application of the methodology described above, however, met with certain difficulties, which are discussed below.

***Difficulties in Applying the Methodology*.** The methodology described above was visualised in the first stages of the project. Once the project started, several new factors came

[4] The cities covered are Delhi, Mumbai, Chennai, Hyderabad, Kolkata, Bangalore, Trivandrum, Ernakulum, and Chengannur.

to light that had a great bearing on the subject of commercial presence in the hospital sector in India, and thus on the survey. In trying to access these companies on the updated list (of May 2001), it turned out that several of these companies do not exist any more or never actually became operational. Some of the FCs also did not work out with existing Indian companies. Thus the list of actual such companies one could interview became much shorter for these cities mentioned above. Finally, 5 FC cases in Kolkata, 3 in Delhi, 2 in Chennai, 1 in Bangalore, 2 in Trivnandrum, and one each in Ernakulum and Chengannur could be interviewed. Thus in all, it was possible to locate and give questionnaires to 15 cases of FC in 9 cities.

Among the domestic hospitals, 1 in Kolkata, 2 in Delhi, 1 in Chennai, 4 in Mumbai and 1 in Hyderabad (a total of 9) could be contacted and questionnaires given. Annex 1 gives the list of foreign and domestic hospitals covered in the survey.

As for consumer surveys, in all 154 consumer surveys were done, covering most of the cities included in the survey of hospitals, except Trivandrum and Ernakulum. The hospitals covered under the consumer survey are listed in Annex 2.

A second problem encountered in conducting the survey was that a large part of the information sought either was not given or could not be given by both the foreign and domestic companies. However, qualitative interviews were held in for all the hospitals and were noted down carefully; these helped greatly towards answering the questions, in addition to the filled-out questionnaires.

Though the original study included data till May 2001, this could be extended to December 2002, since more data became available at the time of writing this paper.

## 3. FOREIGN COLLABORATION: APPROVALS IN THE HEALTH SECTOR

### 3.1 Foreign Investment Policy

The radical economic policy reforms made in India since July 1991 have considerably liberalised the policy regime for foreign direct investment (FDI). Foreign companies have been permitted to invest in almost all industries. The only restrictions that remain are on investment in industries reserved for the public sector and for the small-scale sector.

In several respects, the policy regime for foreign investment in India is quite liberal. The approval mechanism has been considerably simplified. There is no requirement to employ Indian nationals, and the previous restrictions on the employment of foreign technicians and managers have been eliminated. The current policy requires no local sourcing for new and existing foreign investment. There are no restrictions on foreign remittance of dividend and royalty. Repatriation of invested capital, in full or part, is also permitted.

There are two approving authorities for FC: 1) the Reserve Bank of India and 2) the Foreign Investment Promotion Board (Department of Industrial Development, Ministry of Commerce and Industry).

Reserve Bank of India accords automatic approval within a period of two weeks to all proposals for foreign investment up to 51 percent foreign equity ownership in a wide range of high priority industries. Prior to 1996, the list of automatic approval did not include hospitals/diagnostic centers. From 1996, this sector has been included. For this sector, automatic approval for foreign investment is available for foreign equity up to 51 percent.

For cases that do not meet the conditions for automatic approval, the Foreign Investment Promotion Board (FIPB) is the authority for according approval to the proposed foreign investment. The FIPB is a high-powered committee chaired by the Secretary, Industry. Investment proposals up to Rs 6 billion recommended for approval by the FIPB are given final clearance by the Ministry of Commerce and Industry. Proposals for investment exceeding this amount are considered by the Cabinet Committee on Foreign Investment (headed by the Prime Minister).

The non-resident Indians (NRI) and the Overseas Corporate Bodies (OCBs) closely held by them - with over 60 percent of the equity shares of such bodies - have been given more attractive terms for investing in India. For example, they are allowed 100 percent equity investment in the notified list of "high priority industries" for which *automatic approval* is granted. In addition to high priority industries, the NRIs and OCBs are allowed 100 percent equity investment in certain other specified areas which includes hospitals and diagnostic centers.

Once the entry plan for foreign investment is approved by the Reserve Bank of India or FIPB, the actual setting up of the enterprise requires various clearances at the level of state government or local government. These include building plan, land use, environmental clearance, power clearance, etc. It is known that while the approval of foreign investment at the level of central government has been streamlined, there has not been much liberalization of policies at state or local level.

As mentioned above, hospitals, clinics, diagnostic centers etc together comprise one of the areas in which foreign investment is permitted. For NRIs, OCBs and PIOs (persons of Indian origin), the investment could be up to 100 percent equity. For other foreign investors, the specified ceiling limit in equity is 51 percent. But, higher foreign equity percentage is possible with approval for such investment given by FIPB.[5]

### 3.2 Approved Foreign Investment Project in Hospitals/Diagnostic Centers: An analysis

As per the list we could prepare, there were altogether 111 cases[6] of foreign investment in hospitals/diagnostic centers approved in the period January 1991 to December 2002. Of these, only nine are cases of technical collaboration. The total amount of foreign equity approved in these cases of collaboration in hospitals/diagnostic centers, which we could identify, amounts to Rs. 8730 million. There are cases in which the investment envisaged is around Rs 5 million or less. At the other extreme, there are cases in which the amount of foreign equity approved is over Rs 1000 million.

As noted earlier in the 1999 publication of the WHO on GATS for the South-East Asia region, in a large number of cases, the approved foreign equity percentage is high in the range of 90 to 100 percent - even though the binding in the schedule of commitments by India is for a ceiling of 51 percent for foreign equity participation. A large number of NRIs have been given permission to set up hospitals/diagnostic centers, several of them with 100 percent equity participation. But there are cases where foreign equity above 51 percent has been permitted.

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[5] Flow of foreign money as donations to hospitals/medical centers are governed by different set of rules than those applicable to foreign investors.

[6] At the time of the survey (mid 2001), we had a shorter list of 63 cases.

**Table 1.** Foreign Investment Approvals in Hospitals/Diagnostic Centers
January 1991 - December 2002

| Source Country | Investment (Rs. Million) | Percent |
|---|---|---|
| Mauritius | 2157.71 | 24.71 |
| Nris | 1909.51 | 21.87 |
| Canada | 1440.00 | 16.49 |
| USA | 1195.57 | 13.69 |
| UK | 747.23 | 8.56 |
| Germany | 395.61 | 4.53 |
| France | 244.28 | 2.80 |
| UAE | 206.92 | 2.37 |
| Singapore | 198.77 | 2.28 |
| Finland | 80.00 | 0.92 |
| Netherlands | 71.16 | 0.82 |
| Israel | 26.25 | 0.30 |
| Bahrain | 20.00 | 0.23 |
| Hongkong | 15.05 | 0.17 |
| Switzerland | 10.00 | 0.11 |
| Saudi Arabia | 7.57 | 0.09 |
| Australia | 4.56 | 0.05 |
| Japan | 0.18 | 0.00 |
| Italy | 0.04 | 0.00 |
| Total | 8730.41 | 100.00 |

Analysis of foreign investment approvals according to the source country reveals that a large part of the investments - 22 percent - are from the NRIs (Table 1). The most important country source of the investments is Mauritius; investments from Mauritius account for 25 percent of the investment approvals.[7] Next in importance are Canada (16.5%), USA (13.7%) and UK (8.5%).

As regards the location, there are two sets of information: one is the place of registration and the other is the site of the facility. Table 2a indicates the locations of the registered office of the approvals till December 2002, by total investment as well as number of cases registered.

As can be seen, Delhi tops the list based on both the criteria, being the registered office for 32 percent of total investment and 27 percent of all cases. The other important cities in terms of number of cases registered are Mumbai, Chennai and Hyderabad. In terms of total share of investment, Chennai replaces Mumbai. But overall, it can be safely said that a few handful of metropolitan cities dominate the scene as far as location of registered office is concerned.

[7] It is known that foreign investors often route their investments through Mauritius to get tax advantage. This probably explains the large share of Mauritius in foreign investment approvals in health sector.

**Table 2a.** Foreign Investment Approvals in Hospitals/Diagnostic Centers
January 1991 - December 2002, according to Location of Registered Office

| Location of registered office | No. of cases of investment | Percent | Location of registered office | Investment (Rs. Million) | Percent |
|---|---|---|---|---|---|
| Delhi | 26 | 27.37 | Delhi | 2766.43 | 31.69 |
| Mumbai | 14 | 14.74 | Mumbai | 1147.78 | 13.1 |
| Chennai | 11 | 11.58 | Chennai | 1671.00 | 19.4 |
| Hyderabad | 10 | 10.53 | USA | 950.00 | 10.88 |
| Kolkata | 4 | 4.21 | Hyderabad | 553.59 | 6.34 |
| Chandigarh | 3 | 3.16 | Chandigarh | 492.40 | 5.64 |
| Kota | 3 | 3.16 | Kolkata | 274.85 | 3.15 |
| Unindicated | 2 | 2.11 | Unindicated | 237.75 | 2.72 |
| Bangalore | 2 | 2.11 | Vijayawada | 140.00 | 1.60 |
| Thaikkattukara | 2 | 2.11 | Calicut | 133.60 | 1.53 |
| USA | 2 | 2.11 | Bhopal | 73.32 | 0.84 |
| Alwaye | 1 | 1.05 | Bhubaneshwar | 64.40 | 0.74 |
| Bareilly | 1 | 1.05 | Kota | 57.50 | 0.66 |
| Bhimavaram | 1 | 1.05 | Thrissur | 49.89 | 0.57 |
| Bhopal | 1 | 1.05 | Pondicherry | 22.00 | 0.25 |
| Bhubaneshwar | 1 | 1.05 | Patna | 20.00 | 0.23 |
| Calicut | 1 | 1.05 | Udupi | 20.00 | 0.23 |
| Nagpur | 1 | 1.05 | Bangalore | 14.03 | 0.16 |
| Patana | 1 | 1.05 | Nagpur | 14.00 | 0.16 |
| Pondicherry | 1 | 1.05 | Vidyanagar | 10.00 | 0.11 |
| Pune | 1 | 1.05 | Bareilly | 6.60 | 0.08 |
| Salem | 1 | 1.05 | Thaikkattukara | 5.32 | 0.06 |
| Thrissur | 1 | 1.05 | Salem | 3.79 | 0.04 |
| Udaipur | 1 | 1.05 | Udaipur | 1.54 | 0.02 |
| Udupi | 1 | 1.05 | Alwaye | 0.34 | 0.00 |
| Vidyanagar | 1 | 1.05 | Pune | 0.18 | 0.00 |
| Vijayawada | 1 | 1.05 | Bhimavaram | 0.10 | 0.00 |
| **Grand Total** | **95** | **100.00** | **Total** | **8730.41** | **100.00** |

It is important to note that in a number of cases, the office of the Indian party could be located in one city and the proposed site could be in a different location. Does the picture change when one looks at the location of the facility? Table 2b indicates the location of the facility till December 2002; for 22 cases this information could not be obtained.

The table shows that Mumbai (including Greater Mumbai) has the largest share in the value of the proposed investment – almost 30 percent, followed by Chennai. As for the share in the total number of facilities, Delhi tops the list with about 14 percent of all the facilities to be set up there. This clearly indicates that the distribution of the registered offices can be a misleading indicator of how the investment is distributed across the country. The fact that

there is so much concentration of the investment does indicate that resources are flowing to areas that are more investment friendly, and not necessarily areas that need the facilities the most.

**Table 2b.** Foreign Investment Approvals in Hospitals/Diagnostic Centers January 1991 - December 2002 according to Location of Facility

| City | Foreign Equity (Rs. Million) | Percent | Number of cases | Percent |
|---|---|---|---|---|
| Greater Mumbai | 1492.91 | 17.10 | 8 | 8.42 |
| Chennai | 1474.78 | 16.89 | 8 | 8.42 |
| Mumbai | 1005.92 | 11.52 | 2 | 2.11 |
| Delhi | 812.45 | 9.31 | 13 | 13.68 |
| Kolkata | 347.85 | 3.98 | 4 | 4.21 |
| Ernakulam | 179.26 | 2.05 | 6 | 6.32 |
| Jaipur | 160.00 | 1.83 | 1 | 1.05 |
| Ropar | 158.66 | 1.82 | 2 | 2.11 |
| Udaipur | 155.54 | 1.78 | 2 | 2.11 |
| Guntur | 140.00 | 1.60 | 1 | 1.05 |
| Howrah | 80.00 | 0.92 | 1 | 1.05 |
| Bhopal | 73.32 | 0.84 | 1 | 1.05 |
| Bhubaneshwar | 64.40 | 0.74 | 1 | 1.05 |
| Kota | 57.50 | 0.66 | 3 | 3.16 |
| Thrissur | 49.89 | 0.57 | 1 | 1.05 |
| Bangalore | 40.28 | 0.46 | 3 | 3.16 |
| Hyderabad | 39.51 | 0.45 | 5 | 5.26 |
| Bhubneshwar | 30.00 | 0.34 | 1 | 1.05 |
| Pondicherry | 22.00 | 0.25 | 1 | 1.05 |
| Patna | 20.00 | 0.23 | 1 | 1.05 |
| Uttar Kannada | 20.00 | 0.23 | 1 | 1.05 |
| Goa | 14.49 | 0.17 | 1 | 1.05 |
| Pune | 14.00 | 0.16 | 1 | 1.05 |
| Ahmedabad | 10.00 | 0.11 | 1 | 1.05 |
| Chandigarh | 10.00 | 0.11 | 1 | 1.05 |
| Bareilly | 6.60 | 0.08 | 1 | 1.05 |
| Salem | 3.79 | 0.04 | 1 | 1.05 |
| Andhra Pradesh | 0.10 | 0.00 | 1 | 1.05 |
| Unspecified | 2247.16 | 25.74 | 22 | 23.16 |
| **Total** | **8730.41** | **100.00** | **95** | **100.00** |

Table 3 indicates that till 2002, a total of Rs. 8730 million had been approved by way of foreign investment in hospitals/diagnostic centers. A closer look at the data according to the year of approval shows that the bulk of the investment approvals were given during 1995 to 1997. Since 1997, there has been a downward trend in both the number of cases and the amount of foreign investment approved in hospitals/diagnostic centers. In 2002, the amount went up again reversing the earlier downward trend. The reason for the downward trend in foreign investment approvals is not clear. But, it seems that there was an initial enthusiasm

among foreign investors after the health sector was opened up for foreign investment. But, this enthusiasm probably went down over time, but perked up again with continued liberalization policies of the government.

**Table 3.** Foreign Investment Approvals in Hospitals/Diagnostic Centers
Jan 1991- December 2002

| Year | Foreign investment approved (Ruppes Million) |
|---|---|
| 1991 | 0.0 |
| 1992 | 57.3 |
| 1993 | 201.0 |
| 1994 | 70.3 |
| 1995 | 1175.0 |
| 1996 | 750.6 |
| 1997 | 3115.0 |
| 1998 | 975.6 |
| 1999 | 539.9 |
| 2000 | 53.6 |
| 2001 | 257.5 |
| 2002 | 1534.5 |
| **Total** | **8730.4** |

Although, in the period January 1991 to December 2002, foreign investment of about Rs. 8730 million in the health sector had been approved, the actual flow of investment has been much smaller. From the available statistics, it is known that at the aggregate level the ratio of actual foreign direct investment flows to approved foreign direct investment has been about one fifth or less in most years of the 1990s. The same is probably true also of foreign investment in the health sector. Indeed, as noted in section 2 above, when we made an attempt to contact the Indian parties of the FCs approved (as in the list) in the cities selected for the study, many of the host Indian firms/companies could not be traced/contacted.

It may be mentioned in passing that the health care sector is among the most rapidly growing sector in the world economy. It is estimated to generate about US$ 3 trillion per year in OECD countries, which is expected to increase to US$ 4 trillion by 2005. No data are available on global FDI flows in health services. According to one estimate, the FDI inflow in health services in the USA in 1999 was $506 million and inward FDI stock existing in 1999 in USA was $6,318 million. This may be compared with FDI flows in the hospital sector in India during the 1990s. Total amount of FDI approved during the period 1991 to 2002 was about Rs 8,730 million. This comes to about Rs 800 million (or, about $20 million) per year. And, the total investment for this period comes to about $200 million. It should be pointed out that this is only the FDI approvals, and the actual investments must have been far less. The actual flow was probably $4 million per year and the FDI stock in health sector by the end of the 1990 about $40-50 million at most. Compared to the foreign investment in the health sector in the US, this is very small. Obviously, India has been able to attract only a small part of the global FDI flows in the health sector.

But, compared to other countries of Asia, India's performance in attracting foreign investment in hospitals was probably much better. A recent study on foreign investments in

health sector in Indonesia, for instance, reports that there were only 21 cases of approval (Timmermans, 2002: 31). This is much lower than the number of cases approved in India. A study on foreign investment in hospitals in Thailand for the 1990s notes that foreign investment remained small compared to domestic investment. Studying share holding pattern in six important private hospitals in Thailand, the study finds that foreign investment represents only 3% of the total investment in the hospitals (Timmermans, 2002: 34). The relatively larger flow of foreign investment in the hospital sector in India compared to Asian countries appears to be due to a liberal foreign investment policy for hospitals reflected in India's commitment for mode 3 of hospital services under GATS.

## 4. HOSPITALS WITH FC AND DOMESTIC HOSPITALS: A COMPARATIVE ANALYSIS

In this section we present results from the interviews of the FC and domestic hospitals, and summarize the results that emerge from a comparative study of the data.

The comparison of FC and domestic (private) hospitals were done in the areas indicated below:

*(a) Nature of the Agreement/Collaboration (FC hospitals)*: very little information was available from the hospitals on the terms and conditions of the FC agreement. In many cases, the collaboration was primarily initiated as a fund-raising activity by the hospitals, since borrowing within the country was seen as difficult or costly, especially because of high interest rates. In certain other cases, a foreign firm (not operating in the health sector abroad) invested in a corporate hospital in India with a view to getting a good return on investment. This was purely a financial investment without involving any transfer of technology (including knowledge of hospital management). There are other forms that the investments took. For example, an NRI doctor investing in a hospital/clinic/diagnostic center in India, or a group of NRI doctors (with friends) forming a company in foreign country and then making an investment in India to set up a hospital (for example West Bank hospital in Kolkata).

*(b) Type of Services Offered*: most of the FC hospitals were offering technologically advanced services in different areas of medicine. Both the FC and domestic hospitals in the survey were mostly general hospitals, with some offering technologically advanced services in different areas of medicine and surgery. The hospitals were of good repute in terms of quality. From discussions held with the hospital management, it was clear that even though the domestic hospitals did not have foreign equity, in terms of treatment and care provided, they are in general not inferior to the hospitals with FC. One reason for this is the presence of highly qualified and experienced doctors (regular or consultants), as well as investment in sophisticated medical equipment in the hospital. In this regard, the domestic hospitals are similar to foreign hospitals.

*(c) Technology Transfer by Foreign Collaborators*: the general view from FC hospitals was that there was no formal mechanism of technology transfer. Mostly, the initiative of obtaining and learning new technology depended on the Indian counterparts, on an as-and-when basis. The best way of transferring skills that were technology related was in recruiting foreign-trained doctors. The other source of technology was through purchase of equipment. New equipment were bought or imported like any other hospital, and did not specifically differ between FC and domestic hospitals. What needs to be underscored is that the foreign investments did not generally have associated with them a technical collaboration agreement,

nor was there much technology transfer from the foreign collaborator in even an informal manner.

*(d) Terms and Conditions of Contracts of Personnel*: most of the FC hospitals behaved like other domestic corporate hospitals in terms of the kind of contract they would draw up with the staff. The majority of hospitals had a mix of permanent and consultant doctors, at least at the senior level. The consultants were often paid on a fee-for-service basis, though there were some cases of capitation payment too, where the payment was on a per case basis. The junior doctors are generally on the staff of the hospital; in some cases, they are on regular basis, in other cases, they have a short-term contract appointment.

*(e) Profile and Origin (in terms of previous employment) of Personnel*: both the FC and domestic hospitals seemed to be recruiting doctors - specially senior doctors - through contacts, though interviews and panels remained an important way of recruitment. Many said that they try and recruit internationally. The foreign-trained doctors bring in embodied skills and were therefore preferred to domestically-trained doctors. Domestic hospitals followed routine procedures for appointment of junior doctors - advertisement in newspapers, interviews of the applicants and selection by a panel. Nurses and technicians were generally recruited locally through advertisements and interviews for both types of hospitals. In some cases, the domestic hospitals had their own nursing training institute, which supplies nurses. Most of the NRI-run hospitals are managed by senior foreign-trained doctors.

An important point to note is that a substantial percentage of the senior doctors working in the private domestic hospitals were previously working in government hospitals -in some cases as much as 90 percent. At the other extreme, there are hospitals, which hired their senior doctors from other private sector hospitals and foreign countries. The proportion of senior doctors who were working in a foreign country previously is about 10 percent in some cases.

*(f) Profile of Consumers Who Visit These Facilities*: the major users of the FC facilities remain domestic patients, though foreign patients from neighbouring countries constitute about 5-6 cases per month. Almost all the hospitals said they received a majority of middle class patients, especially salaried individuals. The hospitals maintained that they provided free services (to the tune of 10-25 percent) to needy patients. This pattern is also visible in the private domestic hospitals: the major users of these facilities are domestic patients. The patients belonging to the city in which the hospital is located and belonging to the state in which the city is located are the main users. However, there are patients who have come from long distances (from other states), and these constitute a significant proportion of the patients getting treatment. What is remarkable to note here, is that in terms of foreign patients admitted, the domestic private hospitals were not performing any worse than the hospitals with FCs. Rather, some of the domestic hospitals (perhaps, because of their location) were getting more foreign patients relative to the FC hospitals. The survey revealed that almost all the hospitals received people from all strata of the society. However, the proportion of middle-class and poor patients was about 25 percent in a number of hospitals. In almost all cases, there were fee concessions to poor patients: in this regard, again, there were no major difference between the hospitals with FC and the domestic hospitals.

√ *Price and Tariff Structure of Major Services Provided*: there seemed to be considerable variation in the price of services like X-ray, ECG etc offered in these hospitals. The only price that was similar across hospitals was that of a normal delivery. Generally, the prices of services of FC hospitals were at par with the prices of similar services in domestic hospitals.

*(g) Source of Equipment and Drugs; Prices and Duties Paid*: for FC hospitals, while drugs were almost always bought within India, many companies imported their machineries through local agents of foreign companies. There was no differential treatment in terms of duties levied on imported products. Similarly, drugs are always bought inside the country by domestic hospitals. As for equipment, some imported all their equipment when they were set up. Some other hospitals imported part of their equipment and procured the rest in India mostly from agents of foreign equipment manufactures.

*(h) Tax and Other Concessions*: majority of the hospitals in both the categories said they did not get any tax concessions, though a few admitted to some income tax concessions. One hospital mentioned that it got subsidised land from the government, but in that case the government held some part of the equity.

*(i) Links with Current and Future Insurance Companies*[8]: none of these hospitals - FC or domestic - had links with private insurance. However, patients were covered under Mediclaim - a product provided by the public sector insurance companies. Since this was a reimbursement scheme, this was not an issue that concerned these hospitals. All the interviewed hospitals felt that there would be more scope to link up with insurance companies once privatisation picks up speed. In this context, some hospitals thought that the current reimbursement system of Mediclaim was inefficient, and once the TPA (Third Party Administrator) system took off, both consumers and hospitals would benefit from the system and the links between insurance and hospitals will be strengthened. There was a strong feeling that the entry of foreign health insurance companies will make a major change in the health sector, and developing linkages with health insurance companies is therefore very important. Some domestic hospitals mentioned that preliminary negotiations with some multinational insurance companies were going on.

√ *Problems, Suggestions and Views on Foreign Investment in the Health Sector*: the hospitals were asked if they faced any problems from government policies relating to health sector, or if they faced any discrimination in treatment vis-à-vis the domestic hospitals. The answer was mostly in the negative, i.e. the hospitals said they did not face any differential treatment. The management of the foreign hospitals viewed foreign investment as a source of additional funds. In fact, some hospitals stated that it was very costly - in terms of higher interest - to borrow from banks within the country. However, there was a consensus that with more such tie-ups, standards of hospitals will improve via competition, and thus this phenomenon was overall beneficial for the country. The poor state of government hospitals and the increased consumer demand for quality care were reasons cited for the need for more such hospitals. There was also a feeling that there is a large unmet need for health services, and since the government sector or domestic private sector would not be able to invest the required resources, the foreign investment in the sector is good for the society.

As for the domestic hospitals, the management of a number of the domestic hospitals interviewed were of the opinion that the opening up of the hospital sector for foreign investment and the consequent entry of new hospitals with FC is unlikely to affect their operations. Some were confident of their reputation and standing in the market, and felt that given the high quality services they provide they would not face much competition from foreign hospitals. Some others were of the view that they operate at a particular segment of the market with a particular class of patients being catered to, and it would be difficult for

[8] At the time of this research, private insurance had not taken off in a big way, and Third Party Administrator system had just begun. The dominant system was of reimbursement.

foreign hospitals to provide services at the relatively lower prices offered by the domestic hospitals. However, there was consensus that with more such tie-ups, standards of hospitals will improve via competition, and thus this phenomenon was overall beneficial for the country. The poor state of government hospitals and the increased consumer demand for quality care were reasons cited for the need for more such hospitals.

***Comparison between Foreign and Domestic Hospitals: Summary***. In Table 4, we present a comparative picture on key variables for FC and domestic hospitals. There is need for caution in drawing inferences from the table since only a small number of hospitals could be covered in the survey. Yet it is useful to note the similarities and differences between foreign and domestic hospitals.

As the table indicates, there are many similarities between the two types of hospitals. Both domestic as well as FC hospitals upgrade their skills and technologies by importing the latest equipment and getting foreign-trained personnel. The only difference in this respect is that the FC hospitals recruit more heavily from other countries than do the domestic hospitals.

As for doctors, the domestic hospitals seem slightly larger in size than the foreign hospitals in similar categories; i.e. the total number of doctors and consultants are on an average higher in say a general domestic hospital, than a general FC hospital. However, the ratio of nurses to doctors is somewhat higher on an average in FC hospital, which could imply either a greater dependence upon nursing staff by doctors for routine and follow-up care (which could translate into better quality of treatment) or could indicate a somewhat greater emphasis on quality of care, at least in the design of the hospitals. The likely reason is the former, i.e. a greater reliance of doctors on nursing staff, as the other two ratios, doctors-to-bed and nurses-to-bed indicate that the domestic hospitals are probably slightly more inclined towards quality of care, while the FC hospitals are more inclined towards quality of treatment.

The picture is somewhat less clear on salaries and pricing. As far as salaries are concerned, there are wide variations in total remuneration in both types of hospitals. It is difficult to say whether on an average one type of hospitals pay more than the other. The payment system is often complicated, based on regular as well as non-regular components of payment. Most senior consultants and permanent doctors get a fee-for-service payment and/or capitation fee.

Fee for service payments depend on the number of patients, the type/complexity of the procedures, and the number of procedures performed. In some hospitals the doctors also get a share of the profits as bonus. Also, often the consultant doctors have to pay for the consultation rooms. All this makes the total payment quite non-comparable across hospitals. However, the table does indicate that there may not be large differences in the total remuneration of doctors between FC and domestic hospitals. A similar picture emerges with respect to pricing of some basic services. These do vary quite a bit across hospitals, but it does not seem that there are major price differences between hospitals of the two kinds.

**Table 4.** A Comparison of FC and Domestic Hospitals for Selected Variables

| Selected variables | FC | Domestic |
|---|---|---|
| Technology transfer-equipment | Technology transfer is mostly through purchase of equipment from foreign sources. There is no separate component in these collaborations on technology transfer. In case of NRI investment, the issue of technology transfer by the foreign collaborator is not quite relevant. | Same as in the case of FC hospitals-purchase of latest equipment. |
| Skills transfer - personnel | Skills are transferred through recruitment of foreign trained and experienced personnel. For NRI setups, the skills come in through training and experience of the doctors themselves. | Same as in FC hospitals, through recruitment of personnel |
| Hiring of senior doctors & consultants | 70-100% with foreign training and experience, with a few exceptions. For example, one hospital based in Bangalore said they preferred government-educated doctors. | On an average, about 10% of recruitment in this category are individuals who were working in foreign countries previously. |
| Number of doctors, permanent and consultants | Numbers vary widely, (from 40 to more than 200) depending on the type of hospital (general or specialties). Around 40-50 seemed to be more common. | Numbers vary, but generally, domestic hospitals seem to be somewhat large in terms of doctors. |
| Ratio of nurses to doctors | 1.5-2.5. There was some outliers in the South of India with a ratio greater than 4. | 1-1.6 |
| Ratio of doctors to bed | Varies between 0.3-0.8 | 0.9-1.4 |
| Ratio of nurses to bed | Varies between 0.6-1.6 | 1-2.3 |
| Salaries of senior doctors | Varies widely depending on the payment system. Can go up to Rs. 6 lakh per annum | Varies widely. |
| Salaries of junior doctors | Varies widely; could be between Rs. 6,500-20,000 per month | Varies widely; could be between Rs. 7,000-15,000 per month |
| Salaries of nurses | Between 5-7,000 per month | Between Rs. 5-8,000 per month |
| Cost of stay per night | Could range between Rs. 200 to Rs. 2,000 | Could range between Rs. 400-3,500 |
| Cost of X-ray | Between Rs. 80-360 | Between Rs. 140-190 |
| Cost of ECG | Between Rs. 80-Rs. 280 | Between Rs. 100-150 |
| Reduced or free treatment | 10-25% cases | 20-25% cases. |

5. PERCEPTIONS OF CONSUMERS OF FOREIGN AND DOMESTIC HOSPITALS:

## AN ANALYSIS

In all, at total of 154 consumers were interviewed, who had used the facilities of any of the foreign or domestic hospitals. Of the 154 consumers covered in the survey, 55 percent had used the facilities of a foreign hospital and 45 percent had used the facilities of a domestic (corporate) hospital. Forty one percent of the respondents were patients themselves and the rest were relatives of patients. A majority of the interviews were carried out at the hospitals.

There were in all 36 hospitals that the consumers accessed, including both domestic and foreign. Out of these, 10 hospitals were FC, and the rest were domestic. Of the patients interviewed, 85 percent had been admitted to the hospitals for treatment, whereas the rest had either used the OPD or had seen a doctor for treatment.

Table 5 presents the views of the patients/relatives on why they chose the particular hospital.

**Table 5.** Reasons for Choosing Hospital*

(Percent of Patients)

| Type of hospital | Specialized services not available elsewhere | Lower price | Better quality of treatment | Better quality of care | Doctor recommended | Insurance coverage | Proximity |
|---|---|---|---|---|---|---|---|
| Foreign | 35 | 0 | 58 | 38 | 17 | 9 | 12 |
| Domestic | 25 | 16 | 74 | 59 | 29 | 4 | 6 |

* Multiple responses: more than one reason could be given

Interestingly, it is the domestic - rather than the FC - hospitals, which seem to fare better in terms of price and quality. Sixteen percent of the respondents said that domestic hospitals had lower price, whereas no respondent seemed to think that the FC hospitals had any price advantage. As for quality of care and treatment, 74 and 59 percent (respectively) of respondents thought domestic hospitals were better, in contrast to 58 and 38 percent, who thought that the FC hospitals were better.

The FC hospitals had a slight advantage over the domestic hospitals on the fronts of proximity and coverage of insurance.

In the survey, the consumers were asked about the source of information about the hospital of their choice. The main difference seems to be in advertisements - the FC hospitals relied much more in advertising their services than the domestic hospitals, as Table 6 indicates. A higher percentage of respondents using domestic hospitals selected the hospital because of their doctor's recommendation (47%), in contrast to those who used a FC hospital (26%).

**Table 6.** Major Sources of Information about Hospital*****

(Percent of Patients)

| Type of hospital | Friends/relatives | Advertisement | Doctor |
|---|---|---|---|
| Foreign | 62 | 14 | 26 |
| Domestic | 62 | 9 | 47 |

* multiple responses; more than one reason could be given

To get an impression regarding awareness about hospital services among the consumers, the respondents were asked whether they were aware of other hospitals offering similar services in their city, as well as in the country. Ninety percent were aware of similar hospitals in the city and 67 percent in the country. Table 7 gives the reasons for selecting the hospital over other such hospitals.

Again, the results indicate that the domestic hospitals score better over the FC hospitals in terms of better qualified doctors, better equipment and better nursing care. The differences are large enough to be significant. The FC hospitals do slightly better in terms of cleaner environment. With regard to price, none of the patients using domestic private sector hospitals said that they chose the hospital because of price. Interestingly, a very small percentage of the patients using the foreign hospitals said that they had chosen it on price consideration along with other considerations. The is perhaps a reflection of the fact that in terms of prices charged for services, the foreign hospitals are not more costly than similar domestic hospitals.

**Table 7.** Reason Hospital Is Selected over Other Local Hospital*****

(Percent of Patients)

| Type of hospital | Qualified doctors | Better equipment | Better nursing/care | Cleaner/better environment | Better price |
|---|---|---|---|---|---|
| Foreign | 59 | 68 | 49 | 61 | 4 |
| Domestic | 79 | 76 | 68 | 54 | 0 |

* multiple responses; more than one reason could be given

In Table 8, we present the consumers' views regarding the overall quality of treatment in the hospital of their choice.

**Table 8.** Level of Satisfaction with Treatment

(Percent of Patients)

| Type of hospital | Below expectation | Met expectation | Above expectation |
|---|---|---|---|
| Foreign | 9 | 56 | 35 |
| Domestic | 7 | 46 | 47 |

Thus, the consumers were asked whether the quality of treatment was below, above or same as they had expected. If one looks at the last column - above expectation -it is again the domestic hospitals, which score over the FC hospitals. Forty seven percent of the respondents thought that the quality of treatment in the domestic hospital they had selected were above their expectations. This figure is 35 percent for the FC hospitals. Again, a slightly higher percentage - 9 percent - thought that the quality was below what they expected in the FC hospital they had selected, as against 7 percent for the domestic hospital category.

A similar question was asked about quality of care and the results are presented in Table 9. Again, the picture that emerges is the same. The FC hospitals fare somewhat worse (36 percent) than the domestic hospitals (41 percent) in terms of providing above-expectation quality of care. This difference was only a matter of three percentage points between the two kinds of hospitals in terms of falling short of expectation.

**Table 9.** Level of Satisfaction with Care

(percent of patients)

| Type of hospital | Below expectation | Met expectation | Above expectation |
|---|---|---|---|
| Foreign | 13 | 51 | 36 |
| Domestic | 16 | 42 | 41 |

Since expenditures on such hospitals can place a significant burden on consumers, they were specifically asked if they would have paid less at a different local hospital, and if so, by how much. These results are presented in Tables 10 and 11. As Table 10 indicates, 67 percent of the respondents who used the facilities of a foreign hospital were of the view that they would have paid less at a local hospital rather than the selected FC hospital. In contrast, 55 percent of the respondents who used domestic hospitals thought that they would have paid less, had they used a local hospital instead. This reflects a possible perception among the respondents of higher pricing in FC hospitals. The results in Table 11 on the magnitude of difference in prices are obviously somewhat arbitrary, because they are not based on actual differences in payments. But it is interesting to note that a large majority in both the categories thought that the prices would have been at least 10 to 25 percent less in another local hospital, indicating that individuals often end up feeling they were over-charged, irrespective of which hospital they are using. The other point to note is that the difference in perception regarding prices in the selected and another local hospital is almost the same between those who used domestic and those who used FC hospital, except in the range of 0-10 percent.

**Table 10.** Paid Less at a Local Hospital

(Percent of Patients)

| Type of hospital | Yes | No |
|---|---|---|
| Foreign | 67 | 32 |
| Domestic | 55 | 45 |

**Table 11.** Estimate of How Much Less a Local Hospital Would Cost

(Percent of Patients)

| Type of hospital | 0-10% | 10-25% | 25-50% | Don't know |
|---|---|---|---|---|
| Foreign | 4 | 59 | 28 | 9 |
| Domestic | 10 | 60 | 27 | 2 |

Overall, the consumer survey revealed some significant results. The main result is that the FC hospitals do not score higher than domestic hospitals in terms of price or perceptions of quality of treatment and care. Indicators like quality of doctors, better nursing care or quality of equipment do better for domestic rather than FC hospitals. The FC hospitals use advertisements as channels of information about their hospitals, and seem to do better than

domestic hospitals in terms of cleaner and better environment and proximity. The questionnaire did not distinguish between first time and other users, which is a suggestion that should be incorporated in future such study. Overall, the perception of the consumers indicates that a higher percentage is better satisfied with domestic hospitals than with FC hospitals.

## 6. GATS 2000: INDIA'S REQUESTS AND OFFERS FOR HOSPITAL SERVICES

In this section, we present the highlights of the previous round as well as the new round of negotiations to better understand the current implications of the third mode for the hospital sector in India.

### 6.1 Previous Round

There are four categories of services which together constitute health services: 1) medical and dental services, 2) services of nurses, midwives, etc. 3) hospital services, and 4) other human health services. In the previous round of GATS negotiations, a number of countries did not make any commitments for trade in health services, for any of the four categories of health services listed (Adlung and Carzaniga 2001). These include Canada, Argentina, Brazil, Chile, Indonesia, New Zealand, Korea, Philippines, and Sri Lanka.

EU made commitments for medical and dental services, services of nurses, midwives, etc. and hospital services. USA and Japan made commitments only for hospital services.

There were relatively greater commitments for modes 2 (consumption abroad) and 3 (commercial presence) (Adlung and Carzaniga 2001). A number of countries kept mode 1 (cross border supply) unbound. Commitments for movements of natural persons were only partial, i.e. they were subject to various restrictions/limitations.

India made commitments only for hospital services. Even for this service, the commitment was for only mode 3, i.e. commercial presence. India made a commitment of allowing foreign direct investment in hospitals up to 51 percent share in equity.

Of all the services sectors covered under GATS, 'health services' is one of the sectors where there was the least number of commitments and hence little liberalisation of trade achieved.

### 6.2 Current Round

In the current round of negotiations (GATS 2000), it is hoped that more countries would make commitments and those who had made commitments earlier will make greater commitments, so that the process of liberalisation of trade in health services will be pushed forward.

As part of the current round of negotiations, India has made requests to 25 GATS signatory nations for liberalising trade in health sector. Table 12 shows the main focus of India's requests for market access commitments for the health services.

**Table 12.** India's Requests to Other Countries for Market Access Commitments under GATS- 2000 for Health Services

| Mode | Developing countries | | | Developed countries | | |
|---|---|---|---|---|---|---|
| | Medical and dental services | Nurses, midwives, etc. | Hospital services | Medical and dental services | Nurses, midwives, etc. | Hospital services |
| 1 | √ | | √ | | | |
| 2 | √ | √ | √ | √ | √ | |
| 3 | √ | √ | √ | | | |
| 4 | √ | √ | √ | √ | √ | √ |

As can be seen from Table 12, India's request to developing countries is for all the four modes. However, a closer look at the documents seems to indicate that the main focus is on mode 3, and to some extent in modes 2 and 4. As regards the developed countries, India's requests are primarily for modes 2 and 4 for medical and dental services and services of nurses, midwives, etc. For hospital services, the focus is on mode 4, i.e. temporary movement of natural persons to hospitals in developed countries.

Some other points to be noted about India's requests are: 1) quantitative restrictions, numerical quotas, economic needs tests affecting entry of health professionals should be removed, and 2) the qualifications of Indian medical and dental service professionals, and nurses should be recognised.

Turning now to the requests made to India, for medical and dental services and the services of nurses, midwives, etc, the requests are that full market access and national treatment commitment be taken in modes 1, 2, and 3, and horizontal commitments in mode 4. Further, for medical and dental services, joint ventures should be allowed and foreign doctors with national licenses in the country of origin should be allowed to practice for three years or more. For hospital services, the requests are that India should take full market access and national treatment commitments in modes 2 and 3, and remove equity limit of 51 percent prevailing currently.

If the requests made and received by India are any indication of the direction in which further liberalisation will take place, then one would expect greater foreign investment in India's health sector under mode 3 and greater outflow of Indian health personnel to foreign countries under mode 4. Another possible development in the coming years might be increasing investment of Indian corporate sector hospitals in other developing countries. This would facilitate outflow of Indian health personnel to such countries.

In reply to the requests received, India has made an offer. It may be useful to discuss the offer India has made in regard to hospital services. India has offered to raise the foreign equity limit to 74 percent. But, a condition has been brought in. The condition is that the latest technology for treatment will be brought in, which is further subject to the condition that in the case of foreign investors having prior collaboration in that specific service sector in India, FIPB approval would be required. Publicly funded services may be available only to Indian citizens or may be supplied at differential prices to persons other than Indian citizens. Some of the horizontal commitments are also important in this respect. The following two may have implications for foreign investment: 1) Subsidies, where granted, shall be available only to domestic service suppliers, and 2) Access to Scheduled areas and Tribal areas covered under the V and VI Schedule of the Constitution of India may be denied. These last two conditions make the treatment of foreign hospital different from domestic hospitals. Note

however that under national treatment for mode 3, India had put no limitation and that continues. In effect what this means is that certain restrictions which were not stated but actually prevalent have now been made explicit.

For mode 2 (consumption abroad), India has now offered to take full commitment (limitation is changed from 'unboound' to 'none') for both market access and national treatment. For mode 1 (telemedicine) India offers to have no limitation in the matter of national treatment. As for market access under mode 1, there would be no limitation for provision of services on provider to provider basis such that the transaction is between two established medical institutions, covering the areas of second opinion to help in diagnosis of cases or in the field of research (Mode 4 is unbound except for horizontal commitments, i.e. commitment applicable to all services).

## 7. CONCLUSIONS AND IMPLICATION

The following broad results emerge from the study:

- There are still only a handful of successful FC cases in India. Most of the successful cases are either Non Resident Indians getting together to set up a facility, or tie-ups with existing corporate domestic hospitals, which already had an established share of the market and appropriate infrastructure in place. In the Southern India, there are many cases of successful NRI establishments.
- The actual number of successful FC ventures is fewer than the list of proposed collaborations. It turned out that a large number of the listed companies were on paper only, and never really took off. Many of the listed names could not be traced at the addresses listed. [9]
- The larger share of proposed collaborations were from Non-Resident-Indians (NRIs), but at the same time the larger number of aborted collaborations were also from this group. There were also a few cases of foreign collaborators backing out of an agreement due to some obstacles.
- The FC hospitals did not seem to differ greatly either in services offered or in style of functioning from the wholly domestic corporate hospitals. In fact, it was sometimes hard to distinguish the two kinds of hospitals.
- The main reason offered by many hospitals for either existing or proposed FC was insufficient finances. The other reasons were secondary. However, it is also true that once such foreign tie-ups took place, there were other benefits on equipment, personnel and other fronts, that helped improve quality of these hospitals.
- The consumer survey revealed that consumers did not prefer the FC hospitals in any significant way; in fact, while the expectations in terms of quality of care and treatment were higher from these hospitals, these expectations were not always met.

[9] In certain cases, we could verify that the proposed foreign investment did not take place. For example, Dewan Chand Satyapal Imaging Research Center had an approval for collaboration with a German firm (Caritas Tragergesellschaft) for setting up a 200-bed hospital in Delhi. According to our information, the German firm has subsequently withdrawn from the project.

At the end it did not seem as though FC in the hospital sector in India had gathered much speed. This probably had a lot to do with a very successful domestic corporate hospital scene in India. To get a return on foreign investment, the price structure will have to be substantially different in these hospitals; but anything higher than what the corporate sector has to offer is untenable and will not be sustainable. Thus, the majority of such collaborations had to be with existing hospitals. New joint ventures are not attractive to foreigners, who view these collaborations purely from the point of view or profitability.

In the new round of negotiations, India seems to be more open to foreign collaboration because it has raised the foreign equity limit from 51 percent to 74 percent. However, the conditions it is planning to impose are meant to safeguard the interests of the country and can only benefit the health sector and its users. The condition that latest technology is brought in and that publicly funded services may be available to only Indians or may be subject to dual pricing, are both laudable conditions: the first will ensure that FDI continues to upgrade the treatment technologies and the second will fulfil the twin objectives of equity as well as revenue enhancement. Instead of limiting publicly funded services to Indians, the second option of dual pricing sounds more reasonable.

What can one conclude from these results and the analysis? It would be useful to return to the questions we had posed in the introductory section: whether foreign hospitals would add to health service or merely replace them, how far will the entry of foreign hospitals improve the service quality, and whether foreign investment in the hospital sector would affect the access of poorer people in the society to health services?

On the question, whether the FC hospitals are going to add to or replace existing services, the analysis seems to suggest that at present there is no danger of these hospitals replacing current services. The supply of services of these hospitals has not picked up enough momentum yet to be a significant part of the supply of total hospital services in India. If anything, these are likely to add to the current services and meet some of the demand emanating from the consumers. Even if the flow increases after the second round of negotiations are over, it is still unlikely to change the scenario to any significant extent.

As for the contribution of foreign hospitals to service quality improvements, the analysis suggests that the quality of service of foreign hospitals is similar to the quality of treatment and care in domestic hospitals. Thus, foreign investment in the hospital sector may not lead to any significant improvement in the general quality standards of the corporate sector hospitals. But, the entry of foreign hospitals will surely make possible a greater supply of quality services, whether from domestic or foreign hospitals, and this is certainly beneficial to the Indian economy. It is unlikely that with the current supply scenario, these hospitals will have a significant impact on supply of personnel in other sectors like the government sector. However, it must be kept in mind that there is some evidence that senior doctors from established government sector are leaving for the more lucrative corporate domestic hospitals; in fact, the FC hospitals are recruiting much more from abroad than the domestic hospitals. Thus, under the current circumstances, it seems the domestic hospitals - rather than the FC ones - are more likely to entice away some expertise from government hospitals. At the same time, the interviews with management of both kinds of hospitals indicated that supply of skilled doctors is never an issue; if India has more quality hospitals, it may in fact attract several NRI doctors to the country, which is already happening. In sum, it is unlikely that supply of doctors or decline in supply of skilled doctors to existing non-corporate domestic hospitals is likely to be a big issue in the near future.

As for other personnel, the opinion was unanimous that there is a shortage of skilled nurses and even technicians. With increased demand for these staff, it is possible that the supply of quality personnel may go up, especially if the market responds by creating more training institutes for nurses and technicians. Also, at present, large numbers of nurses leave India to go to other countries, and more opportunities in India may stem this outflow.

The issue of equity in the context of the entry of foreign hospitals is an important one. Will the establishment of these hospitals increase the prices of services, and will such increase result in increase of prices elsewhere in the country? The analysis does not indicate that the prices are much different from those charged in domestic corporate hospitals; in fact it was clear that prices higher than those offered in domestic hospitals would render the FC hospitals uncompetitive. The price structure of hospital services is still fairly dichotomised in India, with government facilities offering prices that are very different from those in corporate settings. It is unlikely that this is going to change much. Further, the markets of hospital services are fairly segregated, with the middle and upper income people accessing the corporate sector more, despite some free and/or subsidised pricing in the non-government hospitals. The dependence of the lower economic classes on government hospitals for curative care is going to continue in the near future. The only cause of worry is the effect on quality in the government hospitals. The quality of care in government hospitals is worse than in private hospitals, and care has to be exercised to see that the expansion of the private sector does not accentuate this difference. This is an issue that is not peculiar only to the hospital or health sector, but is true of all such government institutions; this needs to be addressed by the government, which must strive to improve quality of services offered at its facilities. Polarisation of the private and government sectors in terms of both demand and supply of services is a feature of the Indian health scenario, and not due to the entry of foreign players. Yet, these trends may get accentuated if more such firms enter the market.

However, if in fact, the dual pricing system at these hospitals that is being proposed in the latest negotiations is implemented, it is possible that quality may improve in these hospitals. Allowing foreigners to access public hospitals and pay for their services may halt to some extent the deterioration in quality of these hospitals, especially if accompanied by some further administrative changes at the government hospitals like retention of revenue by hospitals for quality improvement and other investments.

To sum up the discussion above, the present scenario of FC in the hospital sector indicates that the FC hospitals can be clubbed with the other domestic corporate sector hospitals in terms of type, quality and range of services offered, as well as in terms of accessibility and availability of services. The entry of foreign funds is likely to have the same effect as the entry of private Indian firms in the hospital sector. On the positive side, with the entry of more such private/foreign firms, the quality, availability, accessibility of services may improve in the private sector, and also supply of skilled personnel in the country may increase. Also, this mode of supply is definitely going to help the other modes of supply - tele-medicine as well as movement of patients and of personnel across borders. On the negative side, there is a possibility that with a higher rate of entry of such firms in the market, there may be some effect on quality in the government hospitals, both in terms of supply of personnel and in the quality of services offered. There is therefore a greater need to focus on quality improvements all around, but especially in the government sector. Accreditation of hospitals and greater regulatory norms need to be some additional areas that would help in ensuring quality and fairness. Some of the quality concerns may be reduced somewhat if the second round of negotiations with dual pricing at public facilities becomes a reality.

Secondly, it is unlikely that the pace of entry of these firms is going to increase in a significant way in the immediate future, because the domestic corporate hospital scenario is sufficient to meet the demand. However, with the entry of private insurance, this picture may change considerably. In fact, it is possible that such new ventures will be set up to facilitate the insurance companies' functioning. It has been suggested elsewhere (Gupta 2002) that the entry of private insurance is going to alter the health sector scenario significantly. There has been very little thought given to the likely repercussions on the health sector. To that extent, greater planning by the government is definitely required, to ensure that the basic objectives of efficiency and equity in health care are being met. But as far as entry of foreign firms in the health sector is concerned, it is not clear that the government has any direct role in facilitating such a process.

The NRI investment is somewhat different from the other foreign investments; in certain cases, NRI investment is not guided by profits, but by the goal of providing services at a reasonable price. A positive side of such investment is that it brings back the human resources the country had lost. Even more important is that quality services are made available to people at large at an affordable price. Such investments need to be encouraged and supported. The tax/incentive system at present make no distinction between a foreign hospital investing in India to make profits, and an NRI setting up a clinic in a small town to serve the local people. Without violating the basic tenets of free trade, the government may try to encourage such investments.

Finally, it should be mentioned that the discussion with some investors during this research gave the impression that there are considerable difficulties (including the problem of corruption) in implementing the foreign investment projects in the health sector even after obtaining approval from the Reserve Bank of India/FIPB. This seems to be an important, if not the main, reason why only a small number of the approved foreign investment projects have been implemented so far. Clearly, to facilitate foreign investment in the health sector the obstacles to the implementation of investment projects need to be removed.

**Annex 1.** List of FC and Domestic Hospitals Interviewed for the Study

| Name of the Hospital | City |
|---|---|
| **Hospital with foreign investment** | |
| Ruby General Hospital | Kolkata |
| Westbank Hospital | Kolkata |
| Assembly of God Hospital and Research Center (funds from Mission of Mercy, Colorado Springs, USA) | Kolkata |
| Wockhardt Hospital and Kidney Institute | Kolkata |
| Peerless Hospital | Kolkata |
| Indraprastha Apollo Hospital | Delhi |
| Dewan Chand Satyapal Imaging Research Center | Delhi |
| Max India Limited (technical collaboration) | Delhi |
| Indian Hospital Corporation (Apollo Hospital) | Chennai |
| Malar Hospital | Chennai |
| Vanchinad Hospitals | Trivandrum |
| Lakeshore Hospital and Research Center Ltd | Ernakulam |
| Kerala Institute of Medical Sciences | Trivandrum |
| Century Hospitals | Chengannur |

| | |
|---|---|
| Wockhardt Hospital and Hearth Institute | Bangalore |
| | |
| **Domestic Hospitals** | |
| Woodlands Hospital | Kolkata |
| Sir Ganga Ram Hospital | Delhi |
| Escort Heart Institute (check name) | Delhi |
| Vijaya Hospital | Chennai |
| Jaslok Hospital | Mumbai |
| Hinduja Hospital | Mumbai |
| Lilavati Hospital and Research Center | Mumbai |
| Breach Candy Hospital and Research Center | Mumbai |
| American Dental Hospital | Hyderabad |

**Annex 2.** List of Hospitals Covered in the Consumer Survey

| **Name of hospital** | **City** |
|---|---|
| AV Hospital | Chennai |
| All India Institute of Medical Sciences | Delhi |
| AMRI Apollo Hospital | Kolkata |
| Apollo Hospital | Delhi |
| Apollo Hospital | Chennai |
| Ashwini Soundaeya Hospital | Chennai |
| Assembly of God Hospital | Kolkata |
| BM Birla Heart Research Center | Kolkata |
| Bellview | Kolkata |
| Breach Candy | Mumbai |
| Kolkata Hospital | Kolkata |
| Clinic-2000 | Hyderabad |
| Dewanchand | Delhi |
| Duncan's Gleneagles Clinic | Kolkata |
| Escort Heart Institute | Delhi |
| Gandhi Hospital | Hyderabad |
| Hinduja Hospital | Mumbai |
| Hinduja Hospital and MRC | Mumbai |
| Isabel's Hospital | Chennai |
| Jaslok Hospital | Mumbai |
| Jaslok Hospital & Research center Mumbai | Mumbai |
| Kamineni Hospital | Hyderabad |
| Kothari Medical Center | Kolkata |
| Kumaran Hospital | Chennai |
| L V Prasad Eye Hospital | Hyderabad |
| Lilavati Hospital | Mumbai |
| Malar Hospital | Chennai |
| Mediciti | Hyderabad |
| NIMS | Hyderabad |
| Peerless Hospital | Kolkata |
| Ruby General Hospital | Kolkata |
| Sir Gangaram Hospital | Delhi |
| Vijaya Hospital | Chennai |

| | |
|---|---|
| West Bank Hospital | Kolkata |
| Woodlands Hospital | Kolkata |
| Yashoda Super-Speciality Hospital | Hyderabad |

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