

Trade and COVID-19 Guidance Note

HEALTH SERVICES TRADE AND THE COVID-19 PANDEMIC

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KEY MESSAGES

- The COVID-19 pandemic has overwhelmed the capacity of some domestic healthcare systems, highlighting the need to allow scarce healthcare resources to move, including across borders, to where outbreaks emerge and are worse. Digital technologies, data, and cross-border e-health services like telemedicine have become important support mechanisms in the response to the pandemic. Allowing temporary movement of health professionals could also help alleviate capacity constraints on domestic health systems.
- In the short-term, countries can adopt measures to help alleviate national shortages of medical providers and facilitate the use of telemedicine in response to the COVID 19 pandemic. These include: (i) removing or lowering restrictions on the movement of healthcare professionals across borders, even if temporarily; and (ii) reducing barriers to telemedicine, including allowing the use of insurance in foreign clinics.
- Medium-term measures should focus on strengthening the global health system and building resilience to future crises. These include: (i) allowing foreign entry of health-related suppliers in order to bring additional resources, new technologies, and new management techniques; (ii) increasing cross-border coordination and collaboration between major research centers for disease prevention and control; and (iii) improving digital connectivity in order to provide better support for healthcare systems.

THE ROLE OF HEALTH SERVICES TRADE IN DEALING WITH COVID-19

Trade in health services could help alleviate the impact of the pandemic by allowing scarce healthcare resources to move to where outbreaks emerge and are worse. The policy response to the pandemic is rapidly disrupting global trade flows in goods but the effects are also acutely affecting services (Annex 1). In the worst hit economies, including China, Europe, and the United States, the outbreak of COVID-19 has also overwhelmed the capacity of medical facilities, highlighting the limits of national and local healthcare systems. Some areas with the highest rates of infection have faced shortages of medical personnel. This is despite the fact that these countries/regions (for instance the region of Lombardy in Italy or New York City in the US) have some of the best developed healthcare systems in the world. Health services trade could therefore help relieve pressure from domestic healthcare systems.

Countries that restrict foreign healthcare workers from working in them risk cutting off their populations from significant resources needed to respond to the pandemic. Very few countries are likely to have sufficient medical personnel to deal with a surge of cases. Collaboration across countries both on the import and export of health services would help mobilize a pool of health professionals to fight emerging health issues and alleviate capacity constraints on domestic healthcare systems, especially given that the pandemic does not affect each population center at the same time. A good example is China, which sent 300 intensive care doctors when the pandemic began to peak in Italy but after it had subsided in China. Another

¹ Trade and COVID-19 Guidance Notes are prepared by the Global Trade and Regional Integration Unit of the World Bank to provide practical measures governments can implement to mitigate the impact of the COVID-19 outbreak. For further information about this note please contact the authors Ian Gillson (Lead Economist, igillson@worldbank.org) and Karen Muramatsu (Consultant, ksturamatsu@worldbank.org), or Antonio Nucifora (Practice Manager, Global Trade and Regional Integration Unit, anucifora@worldbank.org). The authors wish to thank Martin Molinuevo, Roberto Echandi, Pierre Sauvé, Paul Brenton, and Erik Churchill for their invaluable inputs to the note. A full list of Trade and Covid-19 Guidance Notes is available at <https://www.worldbank.org/en/topic/trade/brief/trade-and-covid-19>

example from the Ebola crisis was the response from the East African Community, which sent about 500 health experts to assist in the fight against the disease in West Africa in 2014-16. In the wake of the COVID-19 pandemic, the state of New York issued a directive that temporarily allows mutual recognition of suitably qualified medical and nursing degrees both from overseas and from different states. And in the UK, nearly 3,000 migrant doctors, nurses, and paramedics (and their family members) have had their visas extended for a year to assist in the fight against COVID-19.

Access to the internet and the use of online communications have been a fundamental support mechanism to healthcare systems in the fight against COVID-19. As many countries have introduced lockdowns and social distancing, the use of the internet in some countries has been essential for organizing meetings and disseminating important information. International organizations such as the World Health Organization (WHO) and governments are using media and social media outlets to inform and advise the public, healthcare workers, and governments on the latest news and guidelines on the virus. For example, the WHO has partnered with Whatsapp and Facebook to launch messaging services that provide the latest news and information about COVID-19.

However, the absence of a globally coordinated healthcare response, the maintenance of high restrictions to foreign provision and the closure of borders have all hindered health services trade. Many countries have imposed travel restrictions in order to prevent the further spread of the virus.² Although such restrictions are necessary, they impose additional challenges for healthcare professionals working in the response to COVID-19. Organizations which have contributed to the response against COVID-19 in multiple countries, such as Doctors Without Borders³, are negatively impacted by travel restrictions as doctors are unable to travel to affected countries to help.

While levels of trade in health services remain low, their potential has expanded significantly over the past two decades. Global spending on medical tourism (Mode 2)⁴ increased from US\$2.4 billion to US\$11 billion between 2000-17, but this remains very low as it accounts for just 1.7 percent of international tourism receipts.⁵ However several recent changes make it likely trade in health services will expand more rapidly in the future. Better information, cheaper travel and easier border restrictions have combined to enhance the cross-border mobility of patients and health professionals alike.⁶ Another important role of services trade is to boost the capacity of telemedicine, including across borders, as digital delivery is becoming an important complement or substitute to physical delivery of health services.⁷ Telemedicine is rapidly becoming the first

² In the US, the number of TSA checkpoint passengers decreased from 2,356,802 on April 19, 2019 to 105,382 travelers on April 19, 2020—with passenger traffic in 2020 representing just 8 percent of traffic levels registered in 2019.

³ Médecins Sans Frontières, or Doctors Without Borders, is an international humanitarian medical non-governmental organization renowned for its projects in conflict zones and in countries affected by endemic diseases.

⁴ The World Trade Organization defines trade in services to span four modes of supply: Mode 1, or cross-border trade, are services supplied from the territory of one country into the territory of another (for example, telemedicine). Mode 2, or consumption abroad, are services supplied in the territory of a nation to the consumers of another (for example, health tourism). Mode 3, or commercial presence, are services supplied through any type of business or professional establishment of one country in the territory of another, for example, foreign direct investment (FDI). Mode 4, or presence of natural persons, are services supplied by nationals of a country in the territory of another (for example, a health worker supplying their services in the importing country).

⁵ The US is the largest destination (exporting) market for inbound medical tourists with spending there accounting for 36 percent of the global medical tourism market. The US is also the world's leading outbound (importing) medical tourism market, with US citizens spending around US\$2.3 billion in 2017 on medical tourism services abroad. Turkey, Thailand, Jordan, Costa Rica, and Mexico are leading emerging economies in terms of inbound (exports) medical tourism spending. Kuwait is the second largest source market for outbound (imports) medical tourism, largely due to its government policy of supporting and financing medical procedures abroad. Nigeria is the third largest source (importing) market (World Travel & Tourism Council, 2019).

⁶ For example, in the context of the current pandemic, hospitals in Germany have been treating patients from France, Italy and Spain. Thousands of nurses in Windsor, Canada also travel to Detroit in the US each day to work in hospitals there.

⁷ Advances in information and communication technologies have reduced the impact of geographical barriers to trade (for example telediagnosis and teleanalysis).

line of defense against the coronavirus as it is a powerful complement to physical healthcare systems and its use across borders can help address shortages of doctors, especially in developing countries.⁸

This potential is hindered by a range of restrictions which continue to impede trade in health services:

- The *non-portability of health insurance coverage* prevents people from seeking often less expensive treatment abroad. Web- or app-based medical appointments and consultations are also typically not covered by medical insurance programs, despite some countries changing these regulations recently in response to the COVID-19 pandemic to facilitate remote diagnosis.
- *Restrictions to telemedicine* such as administrative restrictions and privacy protection prevent institutions from providing these services. The health sector is traditionally one of the most averse to cross-border data flows due mostly to reasons of privacy protection. Restrictions to cross-border flows of health data can limit the availability of telemedicine services solely to those services provided domestically.⁹ This can prove severely handicapping for developing countries. For telemedicine, a sound legal framework for digital trade is therefore key to supporting the free flow of data, protect privacy and security, and overall provide a trusted environment for digital exchanges.
- *Localization requirements for non-personal data* also persist for software or app repositories. Where countries require that services providers use domestic servers to provide services (e.g. China), access to medical apps or other software used for telemedicine (or used by medical professionals to assist diagnosis and treatment) may also be limited.
- *Restrictions to the movement of natural persons (e.g. through onerous visa requirements) and lack of recognition of foreign qualifications* limit the ability of medical professionals to work abroad even temporarily. Medical professions such as doctors and nurses rank among the most averse to recognizing competing professionals from other countries. There is a need for recognition of foreign education, experience, qualifications and licensing requirements and procedures.
- *Restrictions to the movement of persons may also be on the export side*, because of concerns about the loss of human capital (or “brain drain”), most notably if public resources have paid for training, and this may be especially sensitive during a pandemic. As a result, countries may prevent health workers from working abroad, even temporarily. That said, not all movements imply economic losses for the home countries. Critical factors are the level of remittances sent back (a direct economic benefit); whether workers leave permanently and whether they find, or would have found, suitable employment on coming home that matches their qualifications and professional aspirations.
- *Limitations to foreign direct investment* in the health care sector, especially where public monopolies exist, have curtailed foreign entry into the health sector in a large number of countries, particularly developed ones.

The overall level of trade liberalization in health services is among the lowest of all services sectors.

Multilateral negotiations aimed at the further liberalization of services trade take place in the context of the World Trade Organization (WTO) General Agreement on Trade in Services (GATS) in which countries can make binding commitments on market access and national treatment across the four modes of supply of services. Commitments in the health sector primarily concern private health services: health services provided by the government are largely unaffected. Overall, WTO Members have made the fewest market opening

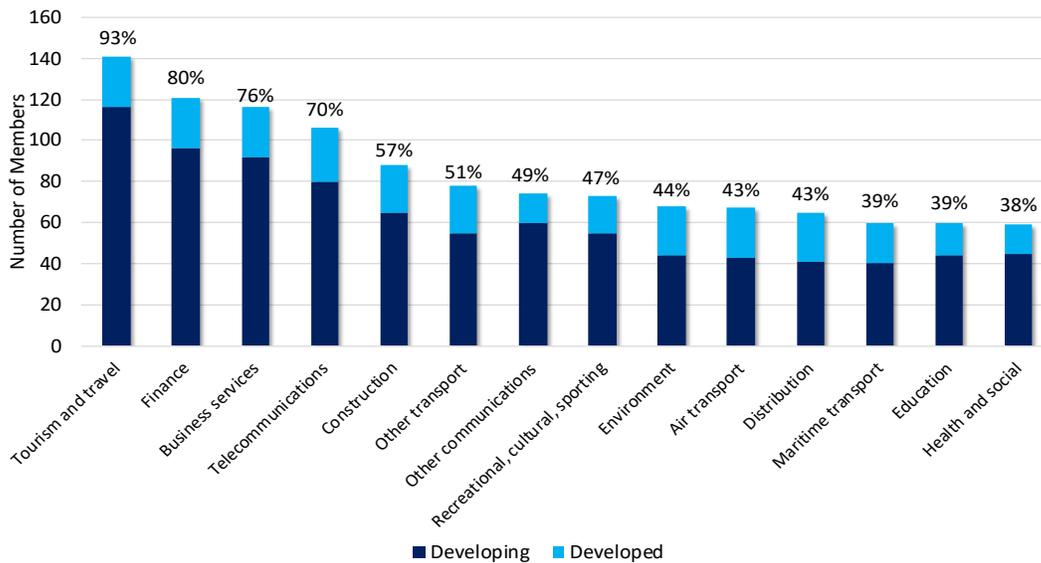
⁸ The global health community is also turning to digital technologies, data, and cross-border e-health interactions to share evidence and experience on diagnosing, preventing, responding, and recovering from COVID-19. This has led to calls in international fora such as the G20 for freer cross-border data flows including flows of information linked to medical research, for example into vaccines.

⁹ Restrictions to data flows are most common in developed countries because developing countries often lag behind in the development of their data policies.

commitments under the GATS to date in the health and social services sector (Figure 1). Considering the four main relevant sub-sectors, medical and dental services are the most heavily committed (62 countries), followed by hospital services (52 countries) and services provider by midwives and nurses (34 countries). Countries have also shown a greater readiness to commit in the health sector in more recent preferential trade agreements (PTAs), notably as the scope for trade in medical tourism has increased (Figure 2). PTAs can also form the basis for mutual recognition agreements for professional qualifications in the sector.

Within health services the fewest GATS commitments concern the movement of professionals (“Mode 4”).¹⁰ Among the four modes of supplying services abroad, Mode 4 (the movement of natural persons to a foreign country to provide health services) has the fewest number of commitments both for market access (approximately 70 percent of countries are unbound, i.e. have made no commitments)¹¹ and national treatment (approximately 66 percent of countries are unbound). Among all healthcare sub-sectors, medical and dental services have the highest number of unbound commitments across all countries, both for market access (94 percent) and national treatment (84 percent) for Mode 4 (Annex 2). Mode 1 (cross-border supply of services (such as telemedicine) has the second least number of commitments across all countries—approximately 48 percent of countries remain unbound for market access and approximately 46 percent of countries are unbound for national treatment. Most commitments have been made for Mode 2 (medical tourism) in which just 21 percent of countries remain unbound for market access and 23 percent are unbound for national treatment. Finally, for Mode 3 (commercial presence to provide health services abroad or foreign direct investment (FDI)), approximately 29 percent of countries remain unbound for market access and 26 percent for national treatment.

Figure 1: GATS level of market access commitments by sector

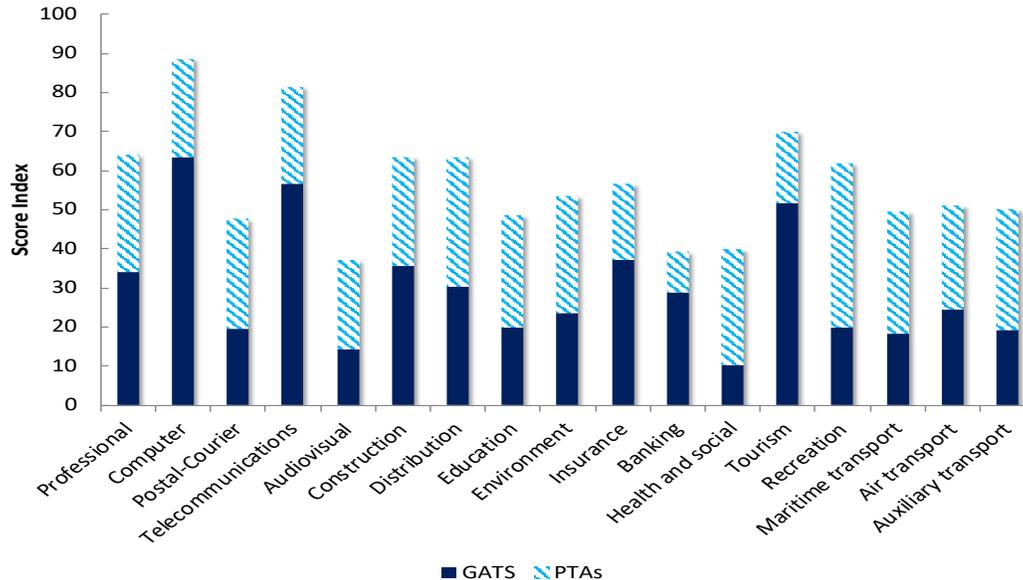


Source: WTO.

¹⁰ This pattern is similar across all other services sectors.

¹¹ An unbound commitment is one that preserves the ability of WTO Members to introduce new restrictive measures in a sector, sub-sector or mode of supply.

Figure 2: Index of GATS+ commitments in services PTAs, by sector



Source: Roy (2019).

Note: Based on commitments undertaken by 53 WTO Members (counting the EU as 1) in 67 services PTAs (Roy, 2014)). The index score is brought within a scale of 0 to 100 for each sector, with 100 representing full commitments (i.e., without limitations) across all relevant subsectors. "GATS" reflects the index value for both GATS commitments and services offer in the DDA. "PTA" reflects the index value for a Member's 'best' PTA commitments across all its PTAs. The score for EU commitments is for the EC-15.

POLICY ACTIONS TO BOOST TRADE IN HEALTH SERVICES

Alleviating national shortages of medical providers and facilitating the use of telemedicine in response to the COVID 19 pandemic

Allowing health workers to move more easily across borders—at least on a temporary basis—would increase access to health services. Collaboration across countries both on the import and export of health services would help mobilize a pool of health professionals to fight emerging health issues and alleviate capacity constraints on domestic healthcare systems, especially if not all systems are affected at the same time.

Increasing the scope for cross-border telemedicine would be a powerful complement to physical healthcare systems. Telemedicine can be used as forward triage—the sorting of patients before they go to a physical clinic. Telemedicine allows patients to be screened while in quarantine, decreasing the risks of exposure to healthcare professionals, other patients, and the community in general. Telemedicine can also be used inside facilities where patients and doctors are in different locations and part of the diagnosis or treatment is done via webcam.

Strengthening the global health system and building resilience to future crises

Supporting greater foreign entry in all health-related services would help countries build resilience to future health crises by releasing pressure on domestic health systems and service providers. Foreign investors bring additional resources, new technologies, and new management techniques that can improve the provision of health services and the financing of health care systems. There would also be direct economic

benefits to developing countries from greater health services trade. FDI in health services creates spillovers that reach far beyond the health sector, including indirect effects on growth, income and employment as well as in other sectors such as construction, transport, telecommunications and a host of business services. In turn, several countries have already shown success in developing export-orientated health services (Annex 3).

Increasing international coordination on health services would enhance diagnostic capacities and help avoid resources being diverted to the highest bidder. Increased collaboration between major research centers including through leveraging existing regional efforts on disease prevention and control where these exist such as through networks of laboratories could help protect against future pandemics.¹²

Opening an improving digital connectivity would also support healthcare delivery. Access to the internet and the usage of online communications have been a fundamental support mechanism to healthcare systems in the fight against COVID-19. Faster access to verified healthcare information facilitates the implementation of precautionary measures.

¹² For example, the East African Community (EAC) has a Disease Prevention and Control Unit that is implementing the East African Public Health Laboratory Networking Project (EAPHLNP) which aims to establish a network of high quality, efficient and accessible public health laboratories for the diagnosis and surveillance of tuberculosis and other communicable diseases.

SUMMARY MATRIX OF POLICY RECOMMENDATIONS

Actions cover both the immediate contagion mitigation phase (short term) and the ensuing recovery phase to strengthen the global health system and build resilience to future crises (medium term).

Policy Action	Responsible Agency
<i>Allowing health workers to move more easily across borders—at least on a temporary basis</i>	
Grant temporary derogations on all restrictions affecting entry and temporary stay for certain categories of technical experts such as nurses, doctors, and laboratory technicians. Consider using mechanisms such as special visas, temporary work permits, temporary licensing regimes, and greater recourse to mutual recognition of foreign qualifications and licensing requirements and procedures.	Ministry of Health / immigration authorities / professional licensing bodies
Coordinate with other countries to allow health professionals to move temporarily abroad to provide services to deal with hotspots on the understanding or through formal agreement that resources be moved back if a hotspot emerges at home.	Prime Minister / President / Ministry of Health / Regional Economic Communities
<i>Increasing the scope for cross-border telemedicine</i>	
Promote recognition and coverage by health insurance of foreign telediagnosis services.	Ministry of Trade / Ministry of Health / private insurance companies
<i>Supporting greater foreign entry in health-related services</i>	
Reduce or eliminate restrictions to FDI in health services (subject to an appropriate regulatory environment).	Ministry of Trade / Ministry of Commerce / Ministry of Health
<i>Increasing international coordination on health services</i>	
Build regional coalitions among like-minded countries for the development of medical capabilities (for both goods and services) to boost capacity.	Prime Minister / President / Ministry of Health / Regional Economic Communities / universities / laboratories
<i>Opening an improving digital connectivity</i>	
Target investments in improving broadband and mobile connectivity, especially for those countries with the lowest rates of access to the internet e.g. Sub-Saharan Africa and South Asia.	Ministries of Telecommunications and ICT / Ministries of Finance / Development Partners / private sector providers of ICT and telecommunications
Reduce barriers to cross-border data flows and coordination measures to increase the interoperability of health data to support the development of telemedicine.	Ministries of Telecommunications and ICT / telecommunications and ICT regulators

ADDITIONAL RESOURCES

Guidance Notes

[Trade and Covid-19 Brief Page](#)
[Managing Risk and Facilitating Trade in the COVID-19 Pandemic](#)
[Do's and Don'ts of Trade Policy in the Response to COVID-19](#)
[Trade in Critical COVID-19 Products](#)
[Trade Responses to the COVID-19 Crisis in Africa](#)

Data & Research

[Database on Coronavirus \(COVID-19\) Trade Flows and Policies](#)
[COVID-19 Trade Watch: April 2020](#)
[Working Paper: The Potential Impact of COVID-19 on GDP and Trade](#)

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ANNEX 1: THE POTENTIAL IMPACT OF COVID-19 ON SERVICES TRADE

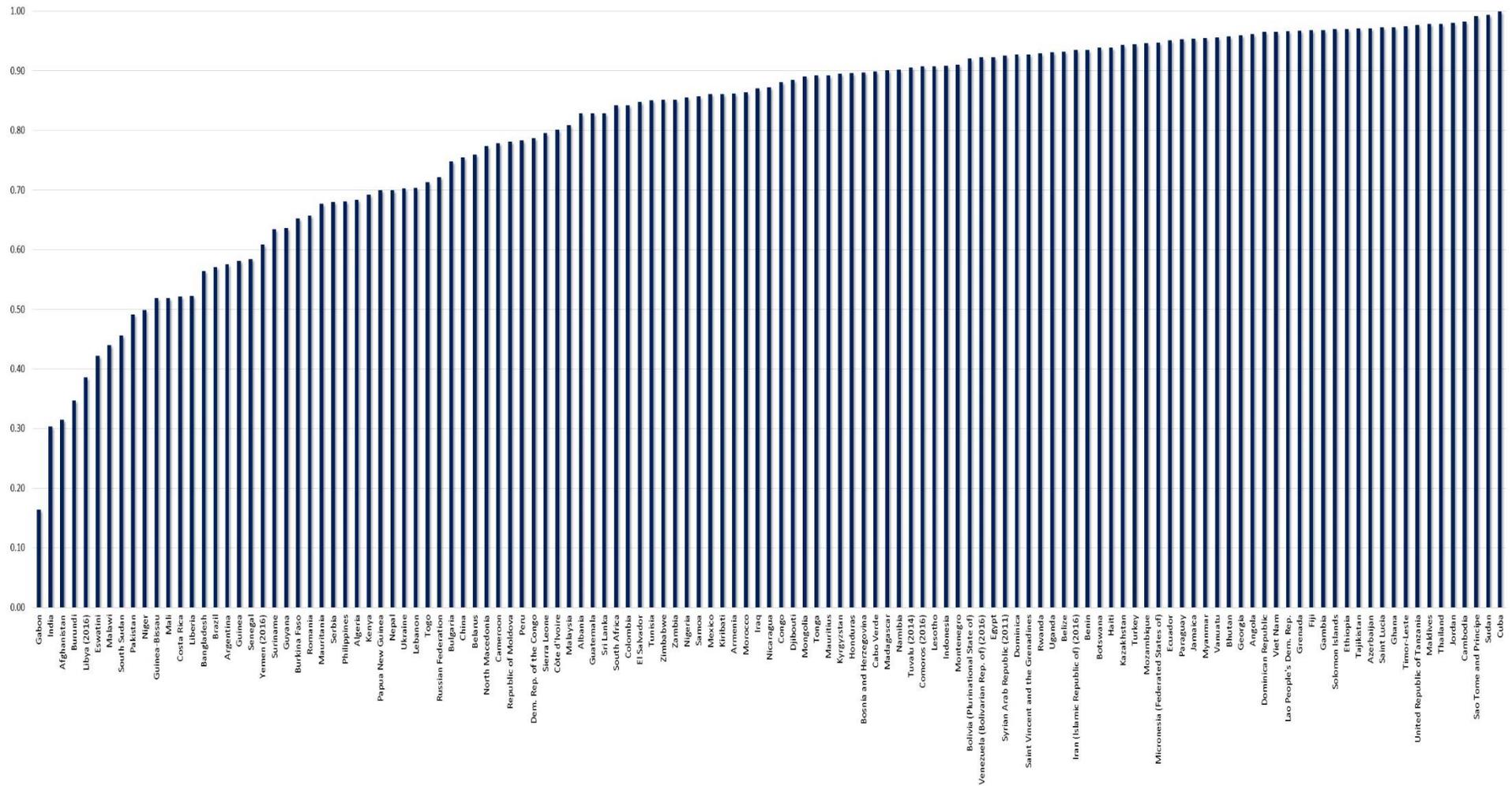
The global response to the health crisis has engendered a supply shock in the world's industrial giants (China, Germany, US) as countries are increasingly implementing national and subnational lockdowns, with movement being restricted, bringing to a halt a wide range of manufacturing and service activities. This has, in turn, fueled a demand shock due to mass job layoffs; wait-and-see purchase-delays by consumers; and investment-delays by firms. Many global multinationals are struggling with retaining the functionality of service centers as employees get sick, are being closed by governments, or just stay away.

In previous global crises, services trade was more resilient than trade in goods. During the Global Financial Crisis, services trade—especially in non-transport—declined by only half as much as merchandise trade. Services trade remained more buoyant for three main reasons. First, on the supply side, services trade was less affected by the crisis-induced scarcity of finance as services trade needs less trade finance than goods trade. Secondly, demand for services contracted less than the demand for merchandise, so the price effects remained much more stable for services than merchandise. This is because services, especially services procured by businesses, are often procured on long term contracts paid on a regular basis (not individual transactions), which makes services prices more stable. In addition, a larger part of demand for services is less discretionary than demand for goods. This is because many back-office services such as accounting and auditing are vital for firms and demand for these is unrelated to their scale of production. Thirdly, the crisis itself generated new services trade as tasks at that time were increasingly being outsourced to reduce costs.

The impact on services trade with the COVID-19 pandemic is likely to be more significant than previous global crises, especially for those services that cannot be supplied via Mode 1. Social distancing and the health impacts of the crisis are negatively affecting trade in 'traditional' services where people must work or interact in close proximity, more than trade in 'modern' services which are more resilient and could even increase as they can be more readily carried out via Mode 1. Traditional services demand face-to-face interaction and with severe closures in tourism, air travel, hotels, restaurants, and entertainment—many of which are supplied by established foreign operators via Mode 3 including franchisees—the impact on trade in these services will be significant. Mode 3 is estimated to account for approximately 59 percent of world trade in services, compared to 28 percent for cross-border supply (Mode 1), 10.5 percent for consumption abroad (Mode 2), and less than 3 percent for the movement of natural persons supplying services (Mode 4; WTO, 2019). Figures 3 and 4 show countries' dependence on exports of traditional services. Countries such as Azerbaijan, Cambodia, Cuba, the Maldives, São Tomé and Príncipe, Sudan, Tanzania and Thailand are among those with the highest shares of traditional services in their services export basket and so *ceteris paribus* will be more vulnerable to the initial economic impacts of COVID-19.

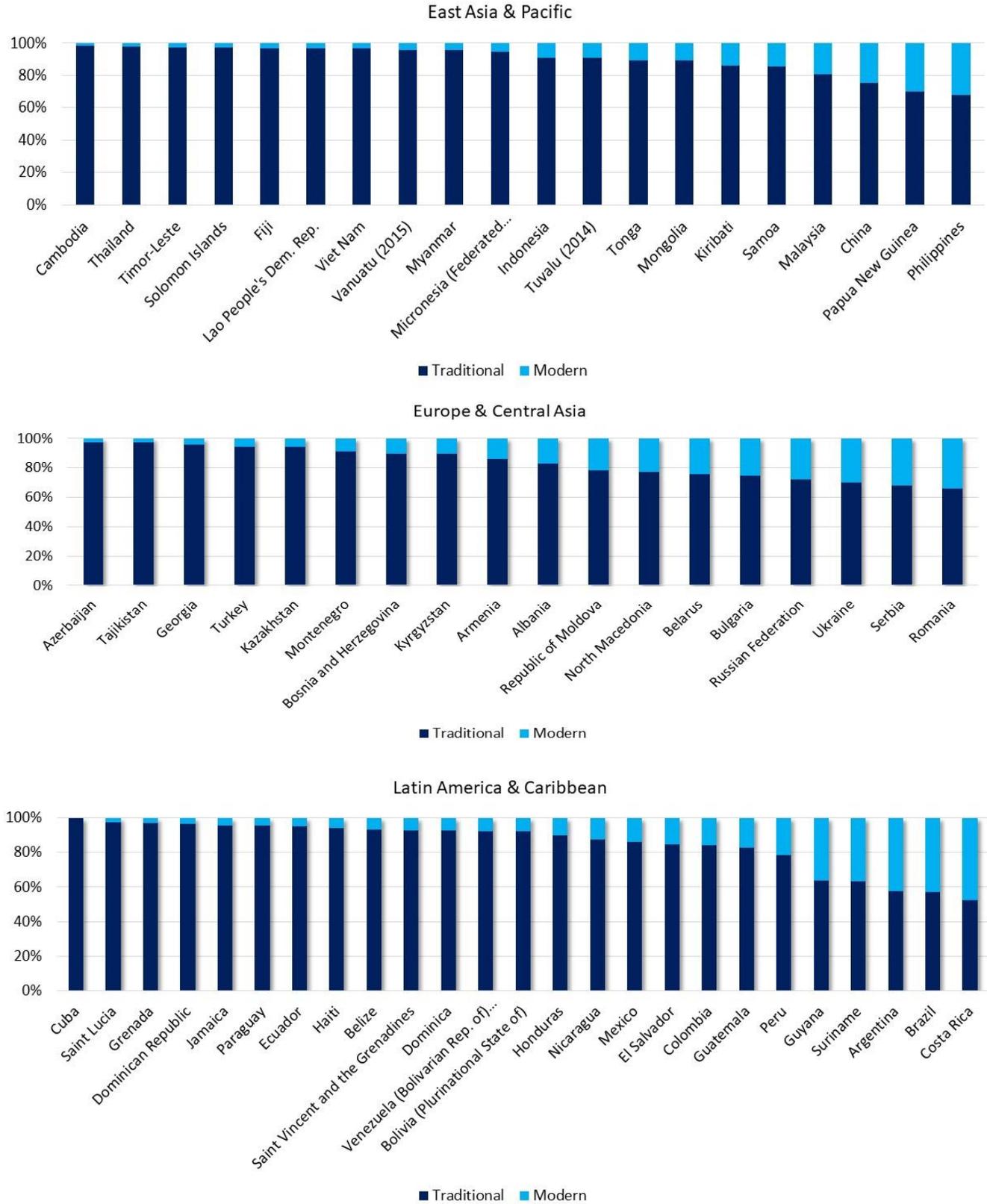
Some modern services provided cross-border will see an increase in demand as a result of the pandemic, at least for those countries that are able to have their workers work from home or can adopt adequate social distancing practices in operations such as call centers. While such increases will likely not compensate for the demand drop in traditional services for most countries, they may make a difference to some economies focused on the export of modern services (e.g. India, Philippines, Uruguay). Those countries more dependent on the delivery of modern services are less dependent on physical presence and more dependent on reliable telecommunications and electrical supplies. Examples of such services include remote access services, transcription of medical records, call centers, banking, insurance, and education. In addition to being important inputs into production, modern services exhibit higher productivity and generate high-skilled and better-paid jobs. However, many modern services sectors such as call centers and other back office operations such as medical transcription and legal research have lower employment intensity and require higher educational levels.

Figure 3: Share of traditional services exports in total services exports, 2017

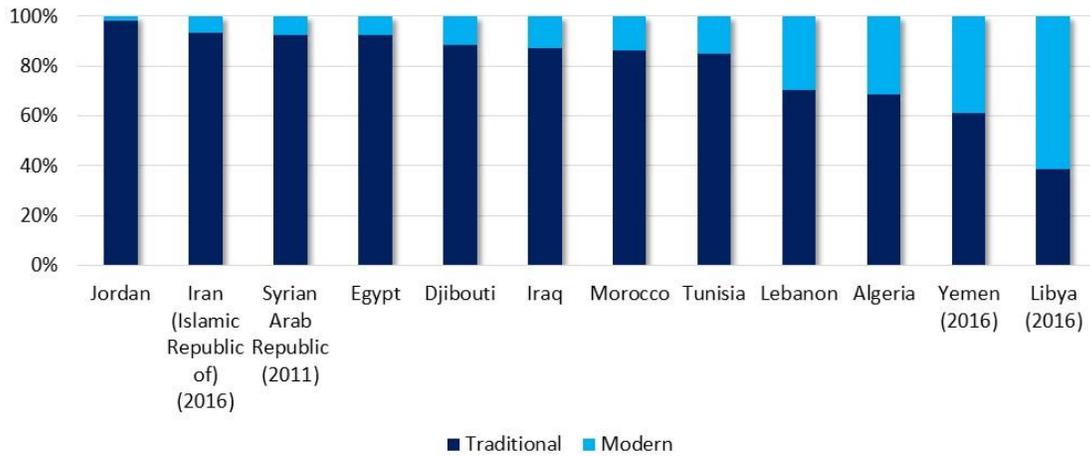


Source: Author's calculations based on data from UNCTAD.

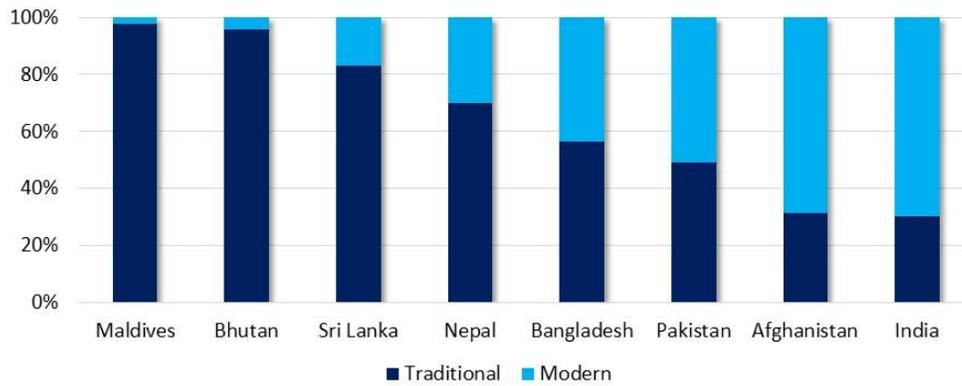
Figure 4: Share of traditional services exports in total services exports by region, 2017



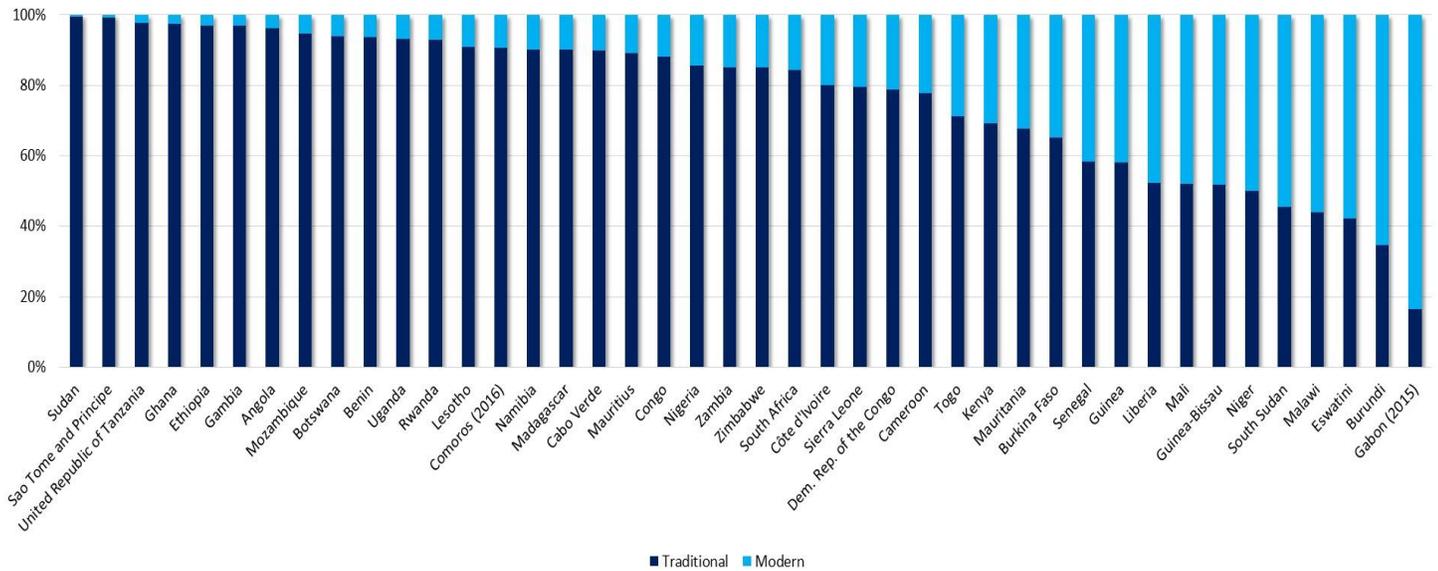
Middle East & North Africa



South Asia

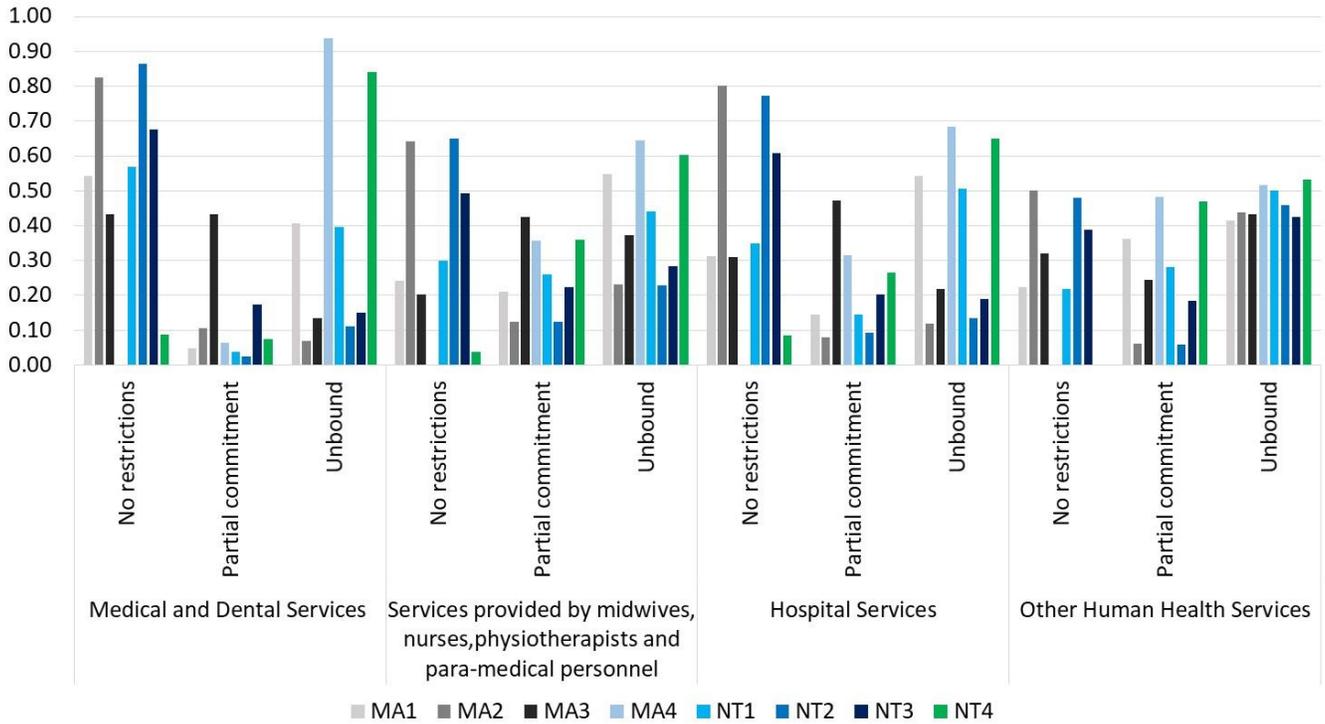


Sub-Saharan Africa



Source: Authors' calculations based on data from UNCTAD.

ANNEX 2: SHARE OF GATS COMMITMENTS FOR HEALTHCARE SERVICES ACROSS ALL WTO MEMBER COUNTRIES



Source: Authors' calculations based on WTO i-TIP Services.

Note: MA#: Market access commitments where # is the mode of supply; NT#: National treatment commitments where # is the mode of supply.

ANNEX 3: COUNTRY EXPERIENCES WITH DEVELOPING EXPORT-ORIENTATED HEALTH SERVICES

India: India exports healthcare providers such as doctors, nurses, and technicians to the Middle East, the US, Canada, UK, and Australia, mainly on short-term assignments. These assignments have the goal of supplying countries experiencing a shortage of healthcare professionals while allowing Indian healthcare providers to upgrade their skills abroad. Foreign patients from both developed countries, such as UK and the US, as well as developing countries, such as Bangladesh, Nepal, and Sri Lanka, also come to India in search of less costly and high-quality treatments, namely surgery and specialized health services (e.g. neurology, cardiology, endocrinology, and urology). Neighboring countries including countries in Central Asia also benefit from India's export of telemedicine (e.g. diagnosis, radiology, pathology). Foreign investors have set up high-tech hospitals with 100 percent ownership as well as in partnership with Indian firms. Indian firms also have partnered with companies abroad to invest in healthcare systems abroad. The presence of high-tech foreign owned hospitals has incentivized a reverse brain drain where Indian doctors are coming back to work at home.

Tunisia: The government's strategy has been to use Tunisia's geographic proximity to both Africa and Europe to attract more foreign patients. Incentives to upgrade the healthcare system include tax exoneration for medical equipment and devices; exemption of value added tax for treatments of foreign patients; a 50 percent tax cut on medical institutions and infrastructure investments; partnerships with foreign companies; setting up medical cities; and investments zones to attract foreign medical companies.

Thailand: Thailand's experience is among the most impressive of all countries, as it has generated a big medical tourism sector geared towards foreign patients that has not resulted in a dearth of practitioners for the domestic health care system, with doctors and nurses obliged in return for publicly funded education to serve in the public system, including in rural areas, prior to working in private hospitals.