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Políticas sociales

Modernization and foreign trade in the health services

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Summary

This document examines the impact of modernization of the health system on foreign trade in health services during the period 1983-1999 and looks at future prospects in this area. It establishes linkages between specific aspects of reform and modernization of the sector and imports and exports of specific services produced or required by the health system and the public.

Firstly, a description is given of the modernization and reform process which has the potential to promote foreign trade in the area of health and a number of theories are outlined in this respect.

Secondly, the effective influence of modernization and health reform linkages on the export and import of health services is examined.

Thirdly, the author looks at policy instruments designed to mobilize or create the national capacity for substitution or for slowing the rate of growth of imports of services generated by modernization and reform.

The document concludes that modernization and health reform in Chile have contributed to internationalization of health, that the development of trade in health-related services and goods is an important and growing part of this internationalization and, lastly, that in order to promote and regulate this trade, policies should not be limited to the national sphere but should encompass the country's trade and integration agreements.

Foreword

Until the 1980s, foreign trade in health services made a marginal contribution to Chile's economy and to providers in its national health system. The export of health services has been a constant since the 1950s, as the result of education provided to professionals from various Latin American countries attracted by the prestige of Chilean centers for higher education and service providers and their patient referrals to top level specialists and centers where they studied their specialties. The importing of services for individuals and services required to develop the national health system involved the services characteristic of a relatively closed economy and a health system dominated by the public sector in terms of delivery, financing, and social security wherein the training of health specialists abroad depended on foreign assistance and limited public financing.

This paper will analyze the development of foreign trade in services in more recent times, marked by the introduction of liberalization (1976-1986) and subsequently strong economic growth associated with modernization and sectoral institutional changes that included the national health system (1987 to the present). The central hypothesis is that those who have made greater progress in the modernization of healthcare now consider exports in health services a functional component of health and a source of considerable income in the future rather than merely as a change in quantitative terms, a change that is probably still marginal. The goal is to define the links between the major elements in institutional change and modernization of the national health system—development of technology and models of care, the emergence of new types of providers and commercial practices and rules of the game in the economy and in the national

health system—and the import and export dynamics of given services produced or required by the system and by the population. This will provide an agenda of policies and public initiatives to promote and regulate the potential for growth in this trade to benefit development of the health system and the national economy.

During the period under analysis, and within the context of new policies on financing and sectoral organization and an opening of the national economy to the world economy, the health system has increased its relationships with other national health systems and systems producing the services needed for its development. In this initial stage, the national health system's imports of services have increased and become more diverse to a greater extent than have exports in services provided to individuals and health organizations in neighboring countries or to foreign tourists or foreigners residing temporarily in Chile. At the same time, there has been import substitution, replacing the health services formerly provided abroad to Chilean residents, and an increase in public and private providers' capabilities for and interest in exporting such services to neighboring countries. These changes have become increasingly dynamic in the period under study and everything points to accelerated export trade in future years.

The first section of this paper will characterize the elements of modernization and institutional change and will explore the linkages that explain their impact on foreign trade in services. The second section will analyze the effective impact of such linkages between modernization and health reform and foreign trade in services. Finally, the third section will develop some ideas on policies and initiatives to foster the development of foreign trade, particularly exports in health services to neighboring countries.

I. Modernization, institutional changes, and foreign trade in health services

Between 1983 and 2000, far-reaching and numerous changes in the national health system have transformed the dominant public sector model that had prevailed since the 1950s into an increasingly heterogeneous model in terms of composition and in terms of the changing relationships in the distribution of resources and power among the different segments or levels: central public, decentralized public, municipal public, semi-public (occupational insurance mutual organizations and companies), private (insurance plans, service delivery centers, private practice) and non-profit organizations. Given that this transformation of the health model is ongoing, the emerging model is neither complete nor consolidated and there are very varied proposals regarding central aspects of its future development.

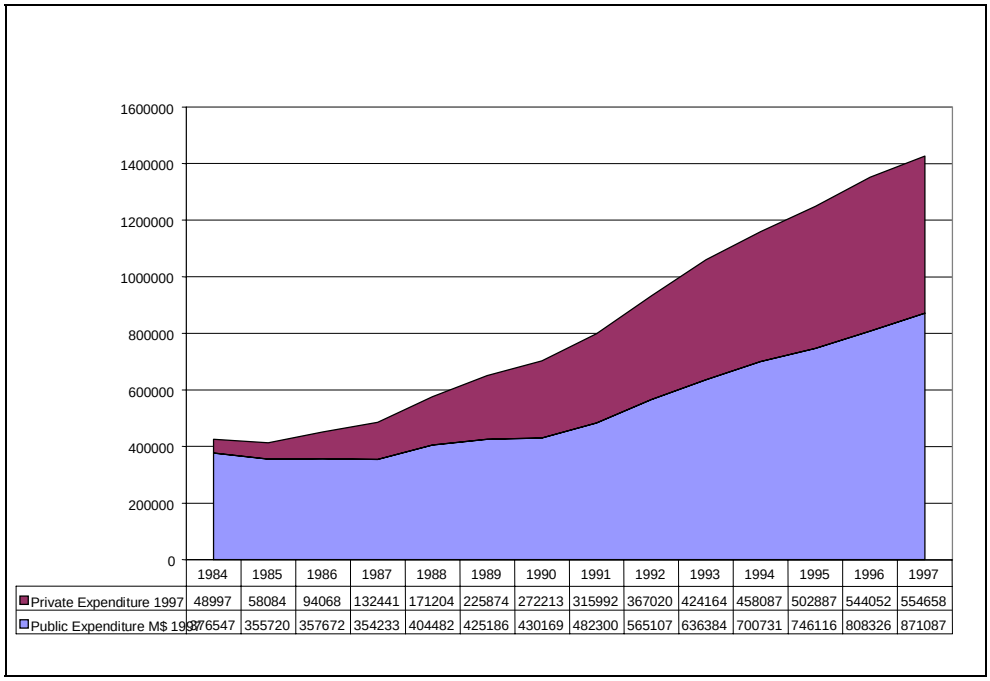
The most important sectoral changes, in terms of their impact on foreign trade in services, are changes in the rules of game for establishing service providers and determining their role in the national system and the development and deregulation of the job market. The transformative effects of these changes have in turn been enhanced by some of the structural reforms implemented since 1974, particularly those relating to the opening of the economy and deregulation of the labor market and of prices for services.

Institutional changes in provides

a) Privatization

The institutional changes in the health system that began in 1983 retain compulsory contributions to health based on payroll, for which the employee is now entirely responsible and voluntary contributions by the self-employed. The most important change was the participant's freedom to choose the institutional modality (public or private) of the provider contracted to handle his/her contributions and to provide services and the creation, along with the public National Health Fund (FONASA), of private agents (ISAPRES) to offer and administer health plans based on those contributions. Initially, the plan developed during the military regime sought to favor the development of private agents until they totally replaced FONASA. However, this changed under the democratic regimes (1990) with increases in budgetary funds allocated to the public health sector and resulting improvements in the quantity and quality of services provided by public providers and subsequently with the proposed transformation of FONASA into something more like an insurance company. In terms of the analysis of modernization and its influence on foreign trade in services, the essential point is that by retaining dual contributions based on taxes and payroll, the Chilean health system has moved toward separating the financial management and service delivery functions, expanding the role of the private sector first in financial management and later in service delivery by increasing the percentage of services that FONASA may purchase from private providers.

Figure 1
HEALTH EXPENDITURE (1984-1997)
(In millions of pesos in 1997)



	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Private Expenditure 1997	48997	58084	94068	132441	171204	225874	272213	315992	367020	424164	458087	502887	544052	554658
Public Expenditure M$ 1997	376547	355720	357672	354233	404482	425186	430169	482300	565107	636384	700731	746116	808326	871087

Source: Boletín Estadístico, Superintendencia de ISAPRES; Depto. De Comercialización y Finanzas, FONASA.
División de Financiamiento CEPAL.

Sectoral privatization has led to increases in the amount and distribution of health financing and spending among the different segments (see Figure 1). The private and semi-autonomous public segments have been most favored, particularly the private segment; they represent 40% of total spending since 1990, with spending per beneficiary in 1997 prices increasing from 129,115 to 142,858 chilean pesos in the period 1990–1997 (see Figure 2). These aggregate figures fail to show that private spending's percentage of the total is higher for some types of services, particularly medical visits, hospitalization, drugs and laboratories, with the public sector continuing to be almost entirely responsible for preventive health services such as vaccinations and subsidies for target populations (e.g., maternity), regardless of whether the subject is privately insured. Maternity subsidies received by private insurance beneficiaries alone represented an amount equal to profits on such insurance plans in 1995. This also created transfers of public resources to private beneficiaries, when private insureds used public services without making the corresponding payment. Based on the 1996 survey of socio-economic characteristics (CASEN), these transfers were estimated to represent slightly more than 10% of such public services. Public transfers to private beneficiaries began to be corrected for services at the secondary and tertiary care levels in the mid-1990s and only last year at the primary care level.

Development of private insurance and public FONASA during the same period has had a similar affect on the distribution of spending. In effect, the ISAPRES operate under a system in which the user freely chooses the system within the health plans' reimbursement levels and there has been an increase in the percentage of freely elected spending in FONASA (25% of total spending in 1998). This has led to an increase in the percentage of freely elected spending and competition among service providers under this modality (secondary and tertiary level facilities and professionals in private practice). The latter have benefited most from the redistribution of total health spending, to the detriment of municipal primary health care facilities and to a lesser extent public services at the secondary and tertiary levels. As a result, we also see a very favorable differentiation in the compensation and income of those working in the favored segments, increasing the number, experience, and professional qualifications of professionals and technicians working on a part- or full-time basis in those segments.

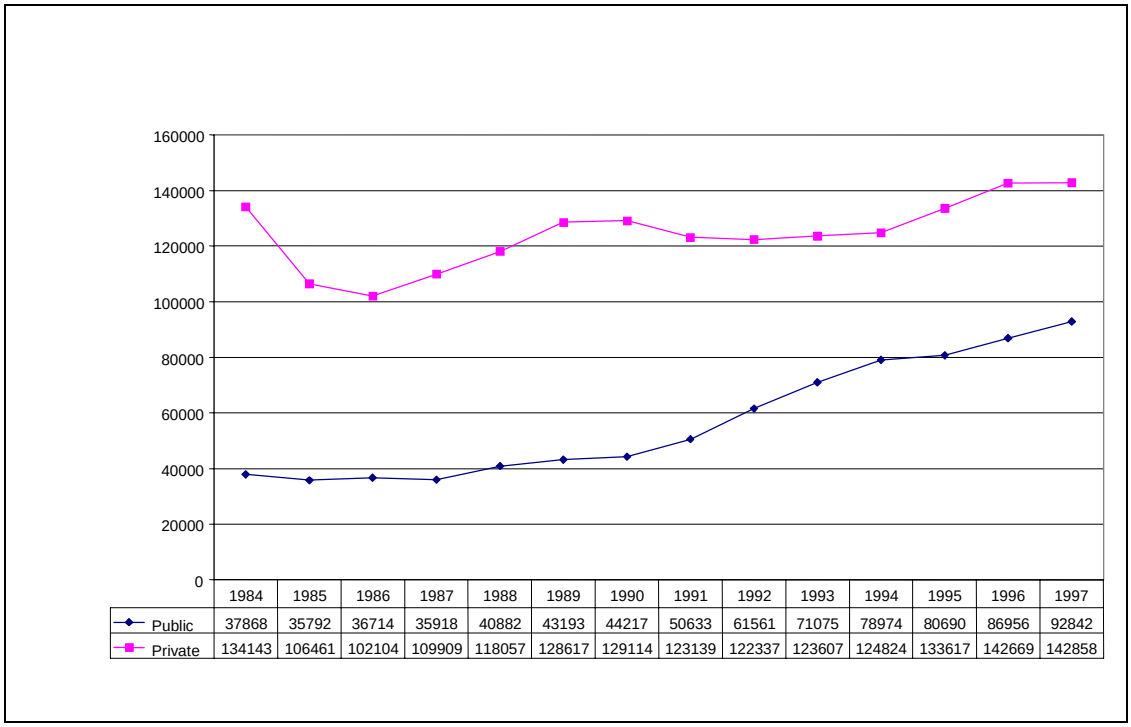
In the context described above, modernization of health services has been a function of the relative availability of resources in the various segments, *i.e.*, modernization has made far greater strides in private facilities and with professionals and technicians in private practice. However, the timing of this differential increase in health spending and its distribution varies greatly. Before the institutional changes in the national health system began in 1983, the crises of 1976 and 1983 and the change in economic model resulted in a reduction of health spending as a percentage of GDP and in the amount spent per beneficiary and consequently in investment in health. This explains the trend toward increasing backwardness in the Chilean health system as a whole in comparison with systems in countries with developed technology and models of care.

In the next subperiod, dating from the institutional changes of 1983 to the beginning of the democratic regime in 1990, private insurance and facilities and occupational insurance mutual organizations steadily increased their participation in total occupational health spending until the former reached 40% of that spending, with spending per beneficiary at about 2.5 times that of the public sector (see Figure 2). This allowed those segments of the health system to increase their investments and to begin strenuous modernization while the three levels of the public sector remained stagnant, increasing their relative backwardness within the system and as compared to the developed countries.

In the final subperiod from 1990 to 1999, the public sector, particularly the secondary and tertiary levels, increased its total and per beneficiary spending and investment, primarily through increased allocations within the National Budget, while the autonomous public and the private

sector increased at a similar rate, propelled by increases in real wages and accordingly in contributions, thus maintaining its percentage of total health spending. The public autonomous and private sectors have thus achieved rapid and continuous modernization since 1983, allowing them to act as a reference for the process of public sector modernization after 1990.

Figure 2
HEALTH EXPENDITURE BY BENEFICIARY
(In chilean pesos in 1997)



	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Public	37868	35792	36714	35918	40882	43193	44217	50633	61561	71075	78974	80690	86956	92842
Private	134143	106461	102104	109909	118057	128617	129114	123139	122337	123607	124824	133617	142669	142858

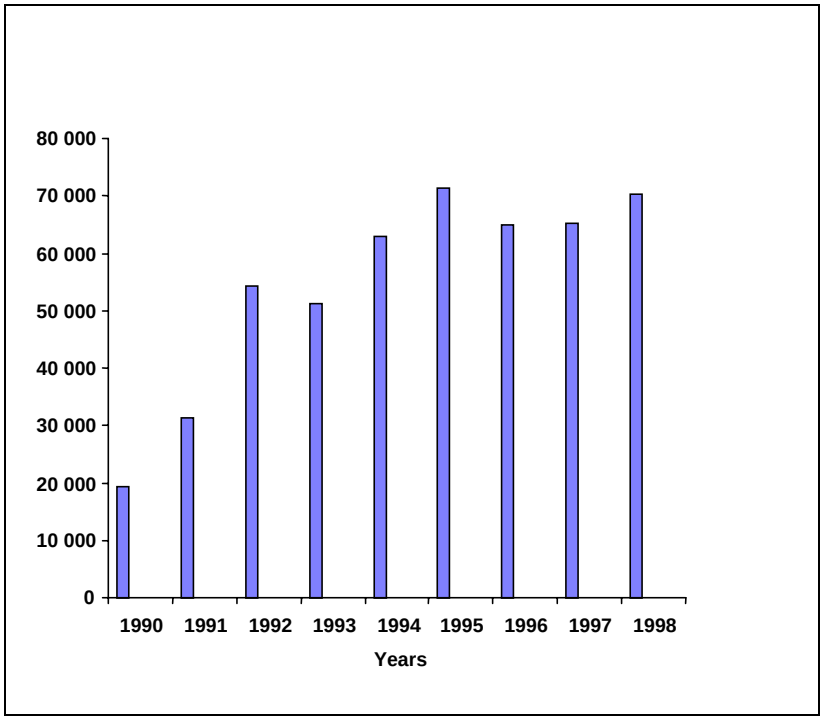
Source: Boletín Estadístico, Superintendencia de ISAPRE; Depto. De Comercialización y Finanzas, FONASA. División de Financiamiento CEPAL.

The rate of modernization accelerated not only because of the greater availability of resources in the period 1983-1999, but also because advantage was made of cumulative technical progress in health in the developed countries where modernization in recent decades, due to spiraling costs per beneficiary, resulted in strong pressure to reduce costs in order to deal with problems in the financing of their systems (Child and Loveridge, 1990). In turn, globalization of health information and the population's increasing access to that information meant that the direction of the population's demand for health care reinforced the direction of the health system decision-makers options' for whom the point of reference was advances made in the developed countries. In the early years, competition among the ISAPRES and among centers and professional providers to attract higher-income contributors and beneficiaries intensified those modernizing pressures.

The effect of this modernization on health equipment imports was not long in coming and continued due to the impetus of increased financial resources, expanded infrastructure, and modernized health equipment (see Figure 3). Since this modernization occurred within a market-based economic model open to international trade, the combination of reduced tariffs on imports and the predominance of market forces in the allocation of resources fostered the tendency to begin modernization by investing in and importing infrastructure and equipment more than by improving health care practices. In addition, given the competition for resources among private providers, these providers were inclined to expand their clientele with more visible investments such as those

in infrastructure and equipment rather than by improving the quality of care, progressively changing or expanding technology and infrastructure. This technical modernization would later made it necessary to work on the quality of care and would foster and dictate the demand for qualified human resources adapted to modernization and for imported services, particularly in professional and technical training, service management, and health facilities design.

Figure 3
MEDICAL EQUIPMENT IMPORTS
(In million dollars)



Source: Boletín Estadístico, Superintendencia de ISAPRE; Depto. De Comercialización y Finanzas, FONASA.
División de Financiamiento CEPAL.

Institutional changes and modernization of the health system coincided with changes in financing method and the multiplication of centers for professional and technical training in health. Financially, the universities and technical training centers that used to depend almost entirely on tax revenues came increasingly to depend on contributions from students. Initially, these contributions could not maintain the traditional levels due to fiscal constraints under the 1982-1990 economic adjustment program, fewer admissions, and limitations on most of the population's ability to contribute to spending on education during those years of recession when increases in real wages were limited. At the same time, the multiplication of technical and professional training centers did not immediately result in a greater supply of health education since the new centers lacked the financial resources and academic maturity to start up very expensive and academically demanding specializations such as those in health. This left unchanged or reduced the ability of those educational centers to educate human resources and even more so their ability to incorporate new specializations and to update the traditional specializations on a timely basis.

Moreover, because the salaries of public sector health workers, who still constitute the majority of workers in the system, continued to fall behind and fees for independent professionals did not experience a general increase until real wages began to improve for the economy as a whole early in the 1990s, interest in entering careers in health declined as compared to other careers such

as business administration that are more closely linked to emerging economic opportunities. Under these conditions, in order to respond to the technical progress afforded by investments in infrastructure and equipment, to obtain the profitability required from these investments, and use them as intended, the health system had to utilize national professionals more intensively, attract foreign professionals and technicians, and supplement both solutions.

The weight of investments and the need to improve the management of service provider centers and insurers, both public and private, led to a natural demand for modernization in health, particularly with increases in the availability of resources and in political and financial controls during the current decade. Thus, in the political arena, democratization made for quicker and more exhaustive evaluation and criticism of the use of budgetary funds allocated for health, particularly because a significant portion of such funds came from a tax reform established by consensus of the government and the opposition. In the financial arena, the view began to prevail that health provider companies should and could achieve and steadily increase profitability as had already occurred in other sectors. Both phenomena led to a similar result: the adoption of evaluation techniques and improved management of public companies and services, with which economists and administrators would come to direct the programming and management of key activities of the national health system.

b) Development of insurance

With institutional changes in the health system in 1983, market forces should in theory determine fees for services and the cost of salaried labor, which had been previously set by the state. However, during the early years a dual system existed in which the market governed in the emerging private sector and centralized, government setting of rates continued in the public sector, with the public sector's influence predominating in the system as a whole. Regarding fees based on rates set by FONASA through negotiation with health professionals and labor costs based on public sector salary schedules, the lack of resources allocated to the public sector due to the economic adjustment program, consistent with the goal of accelerating privatization of services and the transfer of FONASA members to the ISAPRES, meant that increases in prices for professional and hospital care continued to be limited to the private sector and were paid primarily by the upper-income contributors and beneficiaries.

However, deregulation of health care prices, when general increases occurred in household income in the 1990s, would face limits in the participation of the ISAPRES and the continued role of FONASA. The instruments for this are the plans established for members and agreements with service providers within the legal framework governing the operation of the ISAPRES and FONASA. Health plans, by determining reimbursable care and copayments under each program, give economic priority to and foster the expansion of demand for the programs among the insured population and expansion of the supply of services by providers. In turn, the agreements determine standard prices or discounts for care as agreed upon between the insurance plan and individual and institutional providers. These provide an advantage to those who receive them, whether ISAPRES or FONASA. Thus, insurance plans and agreements play a decisive role in determining prices for services through negotiations. Although these negotiations are conducted in the market, they continue to be limited to a set of institutional providers and in some cases, as in negotiations with FONASA, are also limited to representatives of individual providers. Therefore, the evolution of effective demand for health services and the universe of healthcare that benefits from modernization of the national health system are determined primarily by the plans and agreements of the ISAPRES and FONASA, covering about 90% of the country's population.[1]

[1] The rest are served by public providers as indigent.

In this context, the decision to invest in the equipment, management, or human resources of a health care provider for the Chilean population is contingent upon the likelihood that the provider will be included in the health plans of the ISAPRES and FONASA. This has a decisive influence on the return on investment. Thus, private insurance and FONASA have had an important role in the pacing and direction of modernization and on the importing of equipment and professional education for the national health system. This relationship is expressed in various ways, with providers influencing insurers and insurers influencing providers. Thus, some provider centers that specialize in meeting demand among high-income groups or those with health insurance plans that cover very costly treatments are able to incorporate care that captures a type of demand that formerly could be met only overseas, and to provide the service in Chile at lower or equal overall cost. Once national, although relatively limited, capacity to provide the service is established, pressures to make it available spread to other provider centers and it ultimately becomes acceptable to make the service available to the beneficiaries of the ISAPRES and later those of FONASA. In the other direction, a particular type of care, as happened in recent months with diagnostic imaging, may be accepted by the insurance plan but the frequency with which it is prescribed may lead insurers to establish additional limitations on reimbursement to beneficiaries and to limit prescription and delivery.

The influence of insurance on imports and exports in health services is generally more direct and in the Chilean case it has been fostered by tariff reductions and the elimination of restrictions by product characteristic of an exporting model. The inclusion in one or several health plans of the right to receive care abroad depends on the decision of each private insurer and for FONASA on case by case decisions made by Fund authorities. This means that it is reasonable to hypothesize that the ISAPRES and, to a lesser extent, FONASA, have a potential role as facilitators of imports in health services. In addition, as prices for health services in Chile have risen significantly during the period 1983-1999, insurance plans have been able to provide access to care abroad as a cost control measure, with users having the option to receive care in Chile or abroad.

The facilitating role of Chilean insurance plans can be extended to trade in health services particularly when neighboring countries have similar insurance programs with which to establish exchange agreements. This has been true during the period 1983-1999 under analysis. Moreover, because Chilean private insurance plans have played a pioneering role in Latin America, some basic elements of other countries' health insurance programs have been modeled on them. In addition, national insurance programs can include in their plans coverage for care in the centers of other countries for services not provided or insufficiently provided within the country, thus facilitating the importing of such services. Given that during the period under analysis providers in the Chilean national health system have been importing from some other countries the professional training, technical assistance, or equipment that the health system needs, the ability of insurance programs to include care in those countries under their health plans has increased. For example, it is natural that the professionals and technicians trained in centers outside Chile bring with them not only knowledge but also contacts for referring their patients and that they seek assistance in their practice from the center where they studied and from others they met while abroad. Furthermore, the computer revolution will be responsible for multiplying the opportunities for remote consultation, *e.g.*, by sending files via the Internet.

c) Deregulation of the labor market

In a labor-intensive system such as the health system, institutional changes aimed at developing a market economy must take this aspect into account in its priorities and this was true in Chile. As indicated earlier, there was initially a dual system for setting fees and labor costs in the health services, with market forces prevailing in the private sector and administrative price-setting in the public sector, making public sector prices very influential in the system. Given that prices set

in the public sector were very low, the private sector could compete favorably with the public sector in terms of health insurance membership, free choice of service provider, and workplace.

Later, during the 1990s, with decentralization of secondary and tertiary services, the municipalization of primary healthcare, and changes to make FONASA more like a state insurer, differences would begin to arise among the services and among municipalities in wages and salaries paid to health workers as well as in fees for services provided by FONASA, under growing pressure from market mechanisms. Although centralized setting of the public sector salary schedule and of FONASA rates continued, the multiplicity of autonomous agents resulting from decentralization of services, from municipalization, and from greater freedom of action with respect to central FONASA authorities opened the way to competition and market influences. The services and municipalities would not be able to attract staff and FONASA would not be able to attract professionals for inclusion in their free choice lists if compensation did not become increasingly competitive both internally and with respect to compensation in the private sector.

Employee associations in the services and municipalities were collectively successful in adopting a program to adjust compensation in the public sector health services over the medium term. These levels became the base level, and each service or municipality improved upon them so as to be able to compete in retaining staff and filling vacancies. Naturally, particularly in a market with limitations on the labor supply due to inadequate human resources training relative to the rapid expansion in the health system's financial resources and activities during this decade, this greater competition necessitated sustained increases in the compensation of those professionals for which the supply was most limited, a reduction in the level of qualifications required for different positions, and the hiring of personnel abroad.

In this context, unlike what happened in monetary exchange where domestic currency continued to be tied to the dollar, health sector compensation, labor costs, and treatment costs in Chile increased in relation to those in most neighboring countries. This tends to make it more attractive for providers to import equipment, for foreign patients to receive care in their own countries or in countries where care is less expensive, and for foreign professionals to come to work in Chile. This trend grew more rapidly in the importing of equipment and in compensation paid to professionals than in the loss of competitiveness in the services. Thus, technological modernization accelerated, increasing the need for specialized professionals and competition for them in those centers most advanced in the modernization process, and forcing centers less able to modernize to import professionals from abroad.

The lack of specialized human resources has accentuated the tendency to have them rapidly trained abroad, particularly at higher qualification levels with short-term (one or a few weeks) or medium-term (three months to less than a year) training requirements, postponing or eliminating the expansion and adaptation of Chilean training capacity in many specialties. Greater opportunities for professional and technical mobility as a result of specialized professional training in a labor market where such resources are scarce has led professional training abroad, to become a strategic component in the competitiveness of companies and institutions in the labor market.

II. The impact of changes in the national health system on foreign trade in services

During the period 1983-1999, the exporting of services, unlike modernization of the national system, was not an objective of participants early in the process but arose when modernization had already become significant, widespread, and sustainable. Thus, in this section we preferred to begin with the importing of services generated by the process of modernization and then to address the exporting of health services.

1. Importing services for the national health system

a) Professional and technical training abroad

In the interviews during field research for this paper, the specialists in the service provider centers and the directors of health training centers repeatedly expressed concern over how difficult it is to obtain professionals and technicians specialized in the new diagnostic and treatment techniques to meet the growing demand created by increased technical equipment. In particular, there were ethical concerns regarding the relationship between deregulation in the

certification of specialists,[2] with shortages of specialized personnel, and pressures to amortize investments in centers and units. These were fostering an increase in malpractice to unacceptable levels.

In a national health system such as that of Chile that over the last five decades had been able to provide national academic centers for its own specialists and a sizable number of those in other Latin American and Caribbean countries, the scarcity of professionals seemed strange. The interviews with Dr. Valdivieso, Director of the Department of Internal Medicine of the School of Medicine at the Catholic University of Chile and Chairman of the National Certification Commission, allowed us to clarify the problem of the shortage of specialists and to guide the search for relevant information. In reality, the country continues to carry out the training function for health specialists both nationally and regionally and it is possible that the supply of training for specialists is increasing significantly in the new medical schools and technical training centers created in the last two decades. Where it exists, the problem of inadequate supply does not involve long-term specializations (that take several years of training) but rather the subspecialties that only require a few weeks or months in which professionals and technicians receive training in new techniques or methods of care.

The demand for subspecialties in health services provider centers has steadily increased with modernization of the Chilean system over the last two decades, The relative scarcity of skilled staff has greatly increased the earnings of those who obtain such qualifications, increasing the demand for training. This demand must be satisfied abroad, frequently due to the limited domestic supply, and such transfers are further facilitated by reductions in the cost of international travel. Initially, it was customary to go abroad for very short period, in some cases limited to attendance at congresses, informal exchanges with specialists at training centers or healthcare provider facilities, and visits to commercial firms selling medical technology. However, the trend toward seeking training of three months or more has increased in the 1990s, and this includes formal courses and periods of practice in specialized centers.

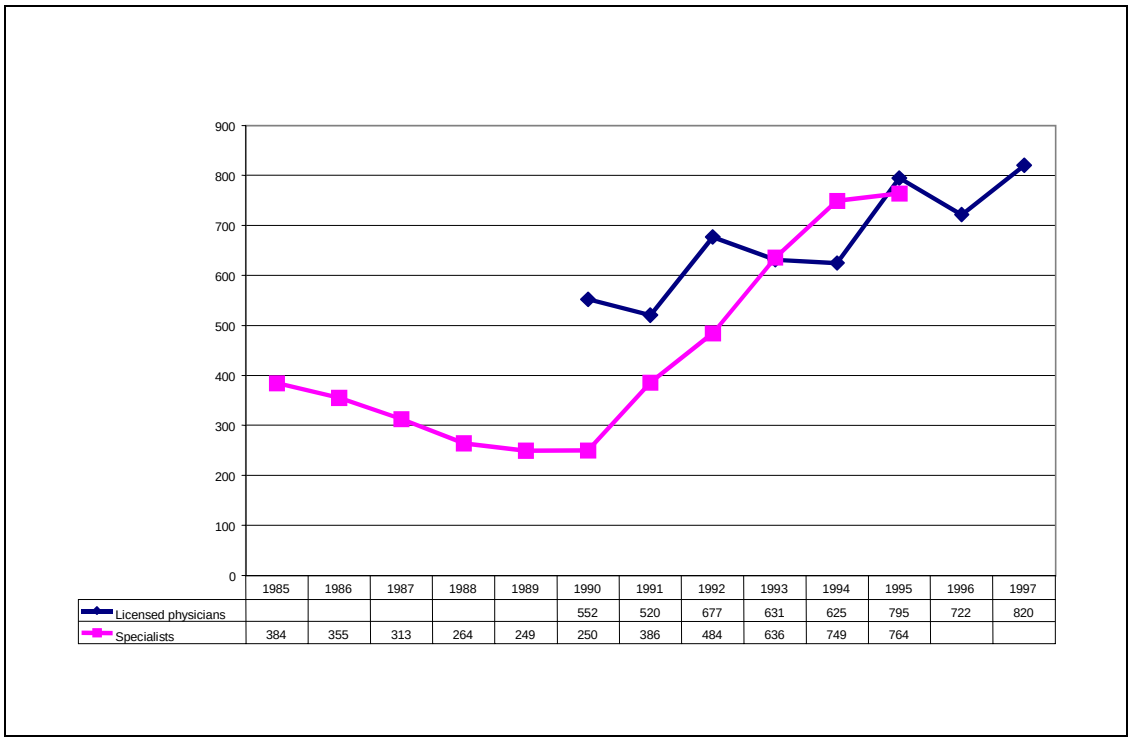
The high assessment of subspecialists and the need and ability to use them to replace specialists in a professional job market where certification is deregulated have begun to cause reduced interest in traditional specialist training. According to the directors of university education centers, for the first time they have begun to have places that go unfilled in programs offered each year in some specialties. Only as an exception, as in a specialty such as ophthalmology, is demand greater than the available supply at the professional level. In the case of university-trained nurses, the specialization received in training centers is not valued, or is not valued by hospitals and medical centers to the same degree as training obtained in-service. This also indicates that there are unresolved problems arising in the field of professional training of specialists, problems that are associated with ongoing modernization in the health system. (Toro Alvarez, 1999).

Traditionally, the training of specialists in Chile or abroad has been financed by the Ministry of Health directly or in combination with contributions from the decentralized services and municipalized primary healthcare and this is one of the incentives that the public sector has for attracting and retaining its professionals. Figure 4 shows the evolution during the period 1985-1997 of financing for such specialized training; its declined proportionately more than the budget for MINSAL services during the subperiod 1983-1989 and then began to increase at higher rates starting in 1990. In addition, the Chilean government benefited from extraordinary contributions in international (bilateral and multilateral) financial and technical cooperation to facilitate the

[2] Although there is a national commission for certification of medical specialties, this certification is still not required in order to work as a specialist. Such deregulation is obviously greater when we go from the professional level to the technical level, given that in this case it is the chief of service or of the attending team who defines the acceptable level of qualification for those running the teams or administering treatments.

transition to democracy and to give priority to social sectors, including health, particularly activities in the public sector. A portion of that international cooperation, especially bilateral cooperation in the case of health, provided MINSAL with technical assistance and an extraordinary program of fellowships abroad. The latter initially favored long-term specialists but increasingly emphasized internships and training in subspecialties lasting for about three months. This reflected, in part, the extraordinary program for construction of infrastructure and hospital equipment promoted by MINSAL under the government of President Alwyin (1990-1994). Over the course of the decade, this bilateral cooperation has been continued by countries such as Spain and England, but not by other countries, leading to a reduction in the funds available for specialized training. However, as of last year this was offset by a project using national funds allocated for primary public health care professionals[3] that amounted to some US$1.1 million in 1998 and US$1.3 million in 1999 (Anriquez, 1998).

Figure 4
GRADUATED DOCTORS ABROAD LICENSED TO PRACTICE IN CHILE AND SPECIALIZED DOCTORS



	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Licensed physicians						552	520	677	631	625	795	722	820
Specialists	384	355	313	264	249	250	386	484	636	749	764		

Source: Universidad de Chile, Facultad de Medicina, Serie de Documentos Académicos No.1, Recursos Humanos en Salud, Formación y Acreditación, agosto de 1999-12-28 ASOFAMECH, Escuela de Medicina U. de Chile, Ministerio de Educación, Ministerio de Relaciones Exteriores.

The number of foreign professionals currently working in Chile according to the information available amounts to several thousands, primarily physicians and nurses. During the period 1990-97, 1 297 physicians were legally authorized to work in Chile, a sixth of them through revalidation of their degrees and the remainder under international agreements, with the number of annual authorizations increasing by 500% during that period. Most of these professionals work in primary

[3] Consequently this fund provides financing for the decentralized services presented in Table 1.

care centers in municipalities that have low-income populations or are relatively isolated geographically, in the health centers of public and private companies also located in isolated areas such as mining areas, and in other cases in first-rate private centers for specializations such as rehabilitation that are not well developed in Chile. Considering the public sector alone (secondary and tertiary healthcare services and municipalized primary services), the number of those working in primary healthcare (540) is currently twice the number of those working in the services (240).

In turn, the new trends in the ownership and organization of healthcare provider centers, with the introduction of national economic groups and international corporations and the influence of risk managers, by establishing more direct links between improved quality and productivity in health care and human resources investment, have increased the marginal role that the institutional private sector had in financing training here and abroad for medical specialties and subspecialties and for other professionals and technicians on health teams. An example of the evolution of private sector institutional participation is provided by the case of one of the clinics that has made great strides in the modernization process. In that institution the number of physicians whose specialization abroad was financed increased from 2 in 1994, before institutional responsibility was assumed, to 21 as of the present, representing approximately US$400 000 this year or approximately one-third of the amount paid by MINSAL for its special project to train professional and technicians abroad.

b) Other services from abroad required by the system

In recent years, the services imported by the national health system and associations—joint ventures between national and foreign companies—have diversified. This is due primarily to the demand for centers of greater excellence in the forefront of modernization. Among these can be included schools teaching architectural design for building secondary and tertiary healthcare centers. For example, the two important expansions of large first-rate clinics currently in progress or being designed have hired the national firm affiliated with an important US consortium. Also, hospital waste management services and patient meals in hospitals are being provided by national firms affiliated with European and North American consortia. Finally, foreign consultants are currently providing health management services to hospitals in the autonomous public sector and to private sector clinics.

c) Health services provided to individuals overseas

The hypothesis that private insurance had been able to play an import-facilitating role by including healthcare services abroad in insurance plans was demonstrated by an increase in the number of ISAPRES and insurance plans offering such benefits over the most recent five-year period. The pioneering institution, the “Vida Tres” ISAPRE, has just included such a benefit in the Mayo Clinic (USA) for all its plans. However, because this generalized benefit was not accompanied by a further increase in premiums, use of the service to date has been marginal. This does not mean that the importing of this service has declined in the country. On the contrary, the Mayo Clinic began to operate in the country through a representative office at least two years ago. In addition, services in Cuba have increased in some categories such as rehabilitation and a company responsible for selling such services has been set up in the country.

In addition, healthcare provider centers generally indicated that they use services such as consultations with foreign centers but that these are free of charge because the consultations are with the professors and centers where their specialists received their specialized training. Also, what generally happens is that specialists refer their patients to centers abroad for diagnoses or for some of the few treatments and interventions not available in the country, and send them with an attending physician, while the services that take the longest time and cost the most are provided in Chile. This indicates an effort to minimize total cost abroad and these practices are promoted by the ISAPRES and FONASA, the customary health plans.

Frequently, the experts consulted have indicated that these health services abroad are included as part of the marketing policy of some private insurance plans, primarily plans for the higher-income population. The services offered and actually used have to date been associated with care in US centers and not in neighboring countries. This means that the effect of the cost of the trip acts as a filter on care, limiting it to care that costs in excess of several thousands of dollars or care that is essential but cannot be obtained in Chile.

The dynamic that begins to operate with this type of importing of services can develop quite significantly when the referral centers for care abroad are located in neighboring countries to which patients are able to travel by land or air at much less cost than to the USA. This would be true of Argentina which, of the countries bordering on Chile, is the country with the most first-rate centers and specialists in all of South America. For example, the fact that the ISAPRES White Cross and Aetna Salud of the international AETNA consortium in Chile have members whose numbers represent a fifth of the total—equal to 800 000 beneficiaries—and that the consortium has an equally significant presence in Argentine insurance, would indicate that the importing of health services from Argentina could increase very rapidly.

1. Exporting health services

a) Import susbstitution

By giving priority in this analysis to import substitution, we want to emphasize its importance in terms of exporting health services in Chile. While not one of the objectives of modernization, import substitution has resulted from the modernization of healthcare that included among its priorities types of care that required that technologies and models of care be developed for diseases such as cancer, one of the most important healthcare fields abroad.

This import substitution occurred during a period when the result of sustained twelve-year growth in the national economy, together with concentration of income in the upper 5% of the population, brought the incomes of such household to the current figure of about US$ 80 000. In other words, the income group most inclined and most able to consume health services abroad increased in terms of its numbers and income level. At the same time, development of the ISAPRES and catastrophic insurance, that recruited most of their members from the households of the upper three levels in the income structure, fostered growth in the demand for more complex and more up-to-date healthcare, some of which was not available in Chile in earlier years. Both factors promoted growth in effective demand for such care, creating a market that is large enough to make the relatively broad provision of such services in the country profitable, as in the case of diagnostic imaging, for example. In some cases, the type of treatment developed (*e.g*., cosmetic surgery, also linked to income growth and concentration) is not considered by many health specialists to be an activity of the sector per se. However, in terms of economic and labor effects, such treatment also represents a contribution to the national economy from health service provider centers.

Another indicator of the dynamic of import substitution is the speed with which the Chilean health system has been able to provide care that until recently led to a flow of patients abroad, as had been the case with rehabilitation, particularly in terms of care provided in Cuba. In response to this, the country's two largest insurance mutuals and a North American consortium developed the project for a first-rate rehabilitation center in Las Rejas, in the metropolitan area of Santiago. In this case, the Chilean center will have the advantage, in addition to eliminating travel expenses to Cuba, of having its own clients as represented by individuals among the two million members of those insurance mutuals who are injured and require rehabilitation.

The greatest limitation on import substitution in the health services, as for other relatively high-cost items, is the narrowness of the national market and its slow rate of expansion. In order to

confront this limitation, first-rate private centers are currently developing two types of strategy: attraction based on institutional prestige; and the formation of networks or systems of centers for care and referral. The first strategy requires that the center be recognized, particularly for its quality of care and the spectacular nature of its successes in cases that have achieved national attention, the reputation of its professional and technical team and its customary clientele, and the attractiveness of its facilities. The formation of networks depends less on marketing and publicity than the first strategy, but requires significant and sustained organizational efforts the complexity of which is discouraging to many of those in charge of first-rate provider centers. This strategy is more feasibly developed by university clinical hospitals whose connection with basic and specialized education allows them to start with a broad base of professional and technical networks that serve as the foundation for organizing the system of centers. This may also be true of centers that are linked through their association with an insurer or that belong to an occupational health facility.

The importance of import substitution in Chile's health services can be appreciated by comparing the behavior of other service sectors such as tourism, where the increase in and concentration of income plus reduced costs for personal travel abroad, especially by air, have also fostered a strong increase in tourism beyond Chile's borders.

b) Services to residents of neighboring countries

Chile shares with Argentina, Brazil, and Uruguay a position that favors exports in health services, in that they offer care that due to its complexity and modernity does not exist in some neighboring countries (Committee on service export companies, 1996). They also play an important role in the education of Bolivian, Ecuadorian, Paraguayan, and Peruvian health professionals, who tend to refer their patients abroad to the centers and specialists they met during their studies. In addition, the development of relatively similar health insurance systems completes the favorable scenario for trade in health services within MERCOSUR and with countries bordering on that customs union.

In the case of Chile, its first-rate centers have captured upper-income and upper middle-income patients from Bolivia and Peru and, to a lesser extent, from Ecuador. Of these, Bolivia has been the source of the greatest flow of patients and the target of efforts to capture them on the part of the ISAPRES and the national healthcare provider centers. During the current decade, sustained growth in the Bolivian economy and consequently in the number of average and high-income households, as well as improvements in road connections and the transport of people between the two countries, have increased the potential for trade in services and Chilean facilities' interest in capturing Bolivian patients.

The first-rate clinics indicated above have established agreements with Bolivian healthcare provider centers and have increased their promotional activities in that country, further concentrating the capture of patients from Bolivia. According to interviews conducted with staff members in the offices of those and other first-rate clinics and hospitals, these facilities act as alternatives or complements to provider centers in the US. In some cases, they provide all the specialized care and in others they combine diagnosis in the US with treatment in Chile. Despite the existence of similar health insurance programs in Bolivia and Chile, some of which have shareholder ties, most patients pay the expenses for care received privately, since only recently have two of the insurers in Bolivia expressly included reimbursement for care in Chile under their plans.

In the tertiary care center that has been most successful in capturing Bolivian patients, the number of hospitalizations went from 236 in 1996 to 314 in 1988, when the number in outpatient care was more than 600. Spending by these patients on hospitalization can be estimated at about US$ 2.5 million and outpatient care can be estimated at over US$ 1.2 million.

The ISAPRES have shown interest in expanding their patient base to middle class households whose numerical importance and income levels have risen sharply along with economic growth. At least three of the ISAPRES have conducted preliminary feasibility studies on starting activities in the Bolivian market. These include the two ISAPRES specializing in the northern health market that last year began activities to capture members and sell services in their associated provider centers. The explanation, according to the ISAPRE specializing in the market in central Chile, lies in the advantage that its northern competitors have due to their location a few hours away by land, while it is than 24 hours away by land.

c) Services to foreigners temporarily residing in Chile

As is known, in the last two decades Chile has been successful in attracting significant flows of direct foreign investment. Together with some geographic advantages that facilitate operations with MERCOSUR and in areas such as mining that Chile has in common with neighboring countries, this flow of foreign investment has led to an increase in the number of resident foreign companies, professionals, and technicians. These professionals and technicians are members of health insurance plans in their home countries and wish to retain seniority and rights in them. They seek to do so by transferring administration of their insurance plan or by utilizing health provider centers that in addition to providing the highest quality of care have experience in operating with foreign insurance plans.

The prior experience that some first-rate provider centers in the metropolitan area of Santiago have in capturing the healthcare of diplomatic and international agency personnel through agreements allowed them to do the same thing with this new segment of temporary foreign residents. The number of households in this segment has grown from a few thousand to several (3-4) tens of thousands over the course of this decade. The provider centers' interest has been due not only to this growth but also, according to staff members interviewed in administrative offices, to the prestige that providing healthcare to this clientele represents and, with respect to patients living in neighboring countries, because the care provided to them represents a much broader and more frequent range of health problems. Thus, capturing this temporary resident segment allows for more rapid growth and modernization for centers that are able to combine it with capturing medium- and high-income Chilean patients and foreigners residing in neighboring countries.

The ISAPRES, perhaps due to the limited numerical importance of the segment, have not shown interest nor have they been pressured by the first-rate provider centers and foreign insurance plans to play a facilitating role and assume responsibility for administering the foreign insurance of the professionals and technical in the companies discussed above. In case of the provider centers, the occasional delays and risks associated with payment are considered marginal in terms of the volume of care and the income generated.

On the other hand, several of the ISAPRES would be interested in exploring the expanding foreign market, that of foreigners in Chile, as there are already close to the two million visitors each year, and this is being promoted through an ambitious national program that could increase these figures by 50% in just over five years. The fact that the country of origin for foreign tourism in Chile and the destination of Chilean tourists abroad is one of the MERCOSUR countries, including Chile and Bolivia, would allow for negotiations in the context of the customs union so as to regulate exchanges among health insurances, expanding the agreement currently existing in the area of health cooperatives. In this regard, the initiatives of some provincial Argentine governments to establish exchanges among their health insurance programs so as to cover tourists residing in both countries would make it possible to develop useful pilot experiments aimed at moving toward integration of health insurance and that would contribute elements for broader integration at the level of MERCOSUR, Bolivia, and Chile.

III. Toward an agenda of initiatives and policies

Our analysis has shown how modernization and institutional changes in Chile's health system have favored internationalization of health, understood as a tightening of the connections between the Chilean health system and the systems of third countries. The development of trade in health services and in goods and services needed by health systems is an important and growing part of that internationalization. In that context, it is logical that policies to promote and regulate such trade cannot be limited to the national arena but must also include the country's integration and trade agreements.

Internationalization and trade in health-related services have played an important role in the modernization of the national system and in the improvements in the population's health that modernization has allowed. They have also had an influence on the evolution of the costs of healthcare and the change in the relative use of the factors of production in health (capital, technology, labor). The initiatives and policies for dealing with some of the problems central to the development of the national health system, such as the shortage of professionals and technicians and the trend toward increased per capita costs for health insurances—including FONASA—will have to consider foreign trade in health services. From that perspective, it would be more desirable to give priority in this section to foreign trade policies on services that are linked to those central problems in the national health system, seeking to select instruments that are consistent with the strategy of international inclusion of the Chilean economy, particularly in terms of Latin American regional and hemispheric integration (Zarilli and Kinnon, 1998).

Exports in health services have been limited to some provider centers and areas in the country, with care provided to foreigners residing in the country being more important than care provided to residents of neighboring countries. These exports, based on the comparative advantages of location and strengthened by recent modernization and the ties of some academic centers and health care providers with professionals in neighboring countries, give the country an intermediary or final role with respect to developed countries (UNCTAD, 1997). Exports in health services are complementary to the important process of replacing imports in the national health system, which will have to continue its current dynamic to respond to the demands for quality and updating of care among high and average income groups, whose numerical importance and average income will grow steadily according to anticipated trends in national economic growth. In this context, the promotion of health exports may provide opportunities for expansion in markets such as that created by tourism, either due to the size of potential flows and promotions under way, or due to the natural association of tourism and healthcare as in the case of thermal baths.

As we indicated in the foreword, the alternatives for the future direction of health reform are far from pointing to consensus, emphasizing the advisability of discussing policy measures within the context of the national health system's current structural heterogeneity and recognizing that, if they are to be effective, the proposed measures must be directed toward fostering consensus-building among the principal participants in the system and must be suitable to the specific features of the different segments (public, private and collective) that comprise the system. Given our aim of encouraging reflection among a group of specialists, an aim which inspires this paper more than do finished instruments, in the remainder of this section we will point to some elements of an agenda of initiatives and policies for promoting and regulating foreign trade in health-related services.

1. The alternatives

The strategies for foreign trade in health services open to Chile in the medium and long term have in common the search for an expanded market in order to make modernization of the national system more feasible and rapid and to keep modernization from accentuating the currently dominant dualism and inequity. Within that context, it is worthwhile to examine the alternative of gradualism based on current formulas for expanding trade versus rapid market expansion based on changing the reference market and the export basket.

The gradualist alternative would consist of maximizing the possibilities of the most promising current formulas, primarily:

- in the area of exports of services, by repeating experiences such as expanding in the Bolivian market based on transportation facilities and by strengthening such experiences through further use of the facilitating role of health insurance programs in the case of some border regions of Argentina;

- in the regulation of imports, by taking greater advantage of long- and short-term training of specialists abroad, using it to supply a national system for ongoing training of health professionals and technicians.

The alternative of rapid market expansion would consist of converting MERCOSUR into the reference market, by prioritizing:

- exchange and integration among public and private health insurance programs of the subregion's countries so as to capture the demand created by flows of tourists among the countries and to foster the development of systems of provider centers in some specializations and border areas;

- development of specializations related to care of the population segment over 60 years of age; and

- development of a system of short-term specialized professional and technical training services on a subregional scale based on specific needs of the subregion and on capturing demand in the rest of Latin America.

For the provider centers that are more advanced in the process of modernization, the gradualist alternative has the advantage of being able to follow the example [of countries] like Bolivia that are beginning to be successful, and repeating the example in regions bordering on northern and central Argentina. On the other hand, there is a risk of accentuating the dualism in the levels of quality and coverage in healthcare in those centers versus those in most of the system, given that it is not financially feasible in a reasonable amount of time to extend a modernization method that is based on the ability to pay among high- and average-income groups to most of the provider centers and to the population served by the national health system.

The alternative of rapid market expansion has the advantage of being able to develop a common method of financially viable modernization for the public and private sector given the reduced costs that would be involved in operating at an economically more efficient technological and organizational scale, providing more equitable benefits to the national population. The difficulties lie in the insecurity that still surrounds MERCOSUR as a plan for integration, which puts the agreements reached in this context at risk of protectionist setbacks, and the resistance of many participants in the system to multisectoral initiatives such as those that involve products that can be developed for the population segment over 60 years of age.

These alternatives for promoting and regulating trade in services should be evaluated with a view to the anticipated demographic and epidemiological evolution of the population, improvements in the duality among subsets of the population for the sake of greater equity, and the health sector's contribution along with other sectors to promoting economic growth and economic openness within the context of subregional (MERCOSUR) and hemispheric integration.

The aging of the population and the growing importance of the population's health problems are the major challenges for the health system that will emerge in the next two decades, jeopardizing the ability to finance the health system due to the high costs represented by the doubling during that period of the percentage of people older than sixty. In epidemiological terms, aging will create a greater incidence of chronic and degenerative diseases in the demand for health, with the resulting need for professionals and technicians specializing in these areas. In financial and ethical terms, aging suggests the need to resolve the current exodus of those over 60 from the private system to the public system when their premiums rise to levels over five times higher than those paid at age 30, with increased copayments required by the ISAPRES, making financing even more precarious, by FONASA or as indigents, for those belonging to low-income groups among the population. The current problem of inequity in health services among income groups in today's population, which is reflected in an epidemiological profile of differential health demand and institutional solutions—generally private for those with higher income and public for those with limited income—would be even more difficult to overcome given the scenario of an aging population (Titelman, 1997).

The relationship between accelerated modernization and institutional changes and equity in health, as could be seen in the analysis of aging, can be summarized in terms of expanding the preexisting equity gap. The concentration of income that has accompanied the increased overall income and household income levels, together with the concentration of higher-income contributors and beneficiaries in health insurance/financing institutions, could only serve to strengthen, in turn, the concentration of the advances of modernization in a limited number of centers, to a greater extent at the higher levels than at the primary care level and among members of the ISAPRES and

the insurance plans against greater or catastrophic risks than in FONASA. As could be seen in the analysis of emerging problems related to deregulation in the labor market and institutional changes in professional education, one of the results of this concentration has been professional migration toward the levels, types of care, and institutions that are better incorporated in the process of modernization at the expense of many public sector healthcare centers, especially those providing municipal primary healthcare that are plagued by deficits and extremely high staff turnover.

A contradiction in terms, but an equally possible advantage of concentration is the appearance of installed capacities underutilized at a regional level in the country together with greater household buying power due to increased incomes and better operation of FONASA, the ISAPRES, and the autonomous public sector institutions thanks to institutional changes. As we will discuss below, this is a very suitable basis for putting together the development of foreign trade in border areas.

Figure 5 shows the evolution of aging among the MERCOSUR countries, including the affiliated countries (Bolivia and Chile), as a subregional group and its evolution in Chile, highlighting the rapidity of growth in the older age groups, per capita spending in health, and relatively similar epidemiological profiles. In this context differences in the stages of developments in the individual health systems. For example, Chile is moving toward specialization in the professions and health teams, a transition that Argentina has already made and Bolivia has not yet begun, favors complementary and exchanges in health services in MERCOSUR.

The background above would indicate that in developing foreign trade in health services the conditions are such that Chile could look positively on the alternative of rapid market expansion from the viewpoint of subregional integration in MERCOSUR. Nonetheless, there are elements in the gradualist approach that should not be discarded, such as the development of trade in border areas, and merit inclusion as specific products in the expansion alternative.

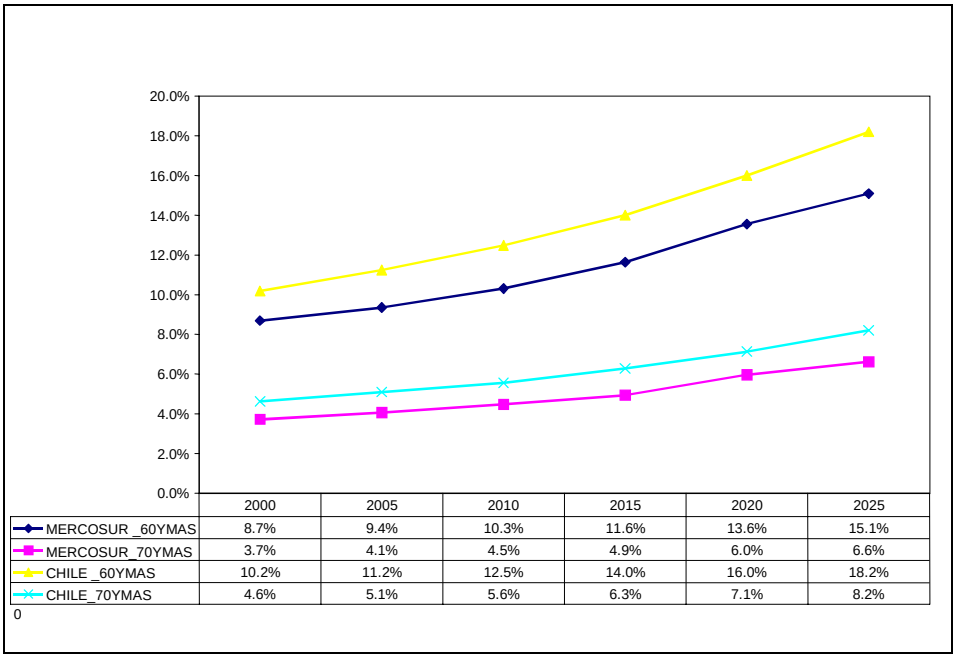
2. Elements of the agenda

a) Give priority to elder care

The expanding market in the demand for healthcare among those over age 60 offers the greatest potential for export of Chilean health services in the MERCOSUR subregion in terms of volume and ability to pay. This is because as long as problems of equity in general and equity in health are not resolved, life expectancy for those over age 60 increases with the level of individual and household income (Rofman, 1994). In addition, it becomes increasingly likely over time within the context of recent social security reforms in the MERCOSUR countries that the elderly will have old age pensions and the number of indigents in that population group may decline.

By the year 2000 this market segment in Chile will amount to 1.55 million people, 704 000 of whom will be older than 70. At the same time, in the MERCOSUR countries as a whole, plus Peru as a neighboring country, there will be 23.12 million, 9.92 million of whom will be older than 70. Within twenty-five years, there will be 3.55 million in Chile and 52.58 million in MERCOSUR, of whom 1.6 million and 23.2 million, respectively, will be older than 70. The greatest geographical concentration of this market is and will be in the central regions of Argentina, in Uruguay and Southern Brazil and these areas coincidentally account for significant numbers of people within the MERCOSUR subregion who travel to Chile, making it reasonable to travel for specialized health care.

Figure 5
MERCOSUR AND CHILE
(Population evolution of 60 and 70 and older)



	2000	2005	2010	2015	2020	2025
MERCOSUR _60YMAS	8.7%	9.4%	10.3%	11.6%	13.6%	15.1%
MERCOSUR_70YMAS	3.7%	4.1%	4.5%	4.9%	6.0%	6.6%
CHILE _60YMAS	10.2%	11.2%	12.5%	14.0%	16.0%	18.2%
CHILE_70YMAS	4.6%	5.1%	5.6%	6.3%	7.1%	8.2%

Source: CELADE, Boletín Demográfico No.62, julio 1998-América Latina: Proyecciones de Población 1970-2050.

Note: MERCOSUR incluye además Chile y Bolivia.

Specialization in health care for the elderly is both a priority in Chile and an expanding market in areas on its borders based on recent travel of near neighbors of MERCOSUR, which are also the areas with the highest income in that subregion. This allows for favorable evaluation of initiatives and policies that promote the development of health services products in Chile designed for this market and of the potential for rapid expansion due to population growth and effective demand in that market.

Some health services products for export to the population aged 60 and over in MERCOSUR countries would require greater emphasis on or incorporation of some specializations and modalities of care currently underdeveloped or nonexistent in Chile. There would thus be a lag in comparison with other countries of the subregion such as Argentina. For other products such as rehabilitation, there are recent and significant initiatives in progress, although they are limited to occupational health. For still other products such as health care services in association with the development of thermal baths, Chile has practically no experience. This development of specialties associated with the health care market for those over age 60 would need to be clearly defined for Chile in the short term.

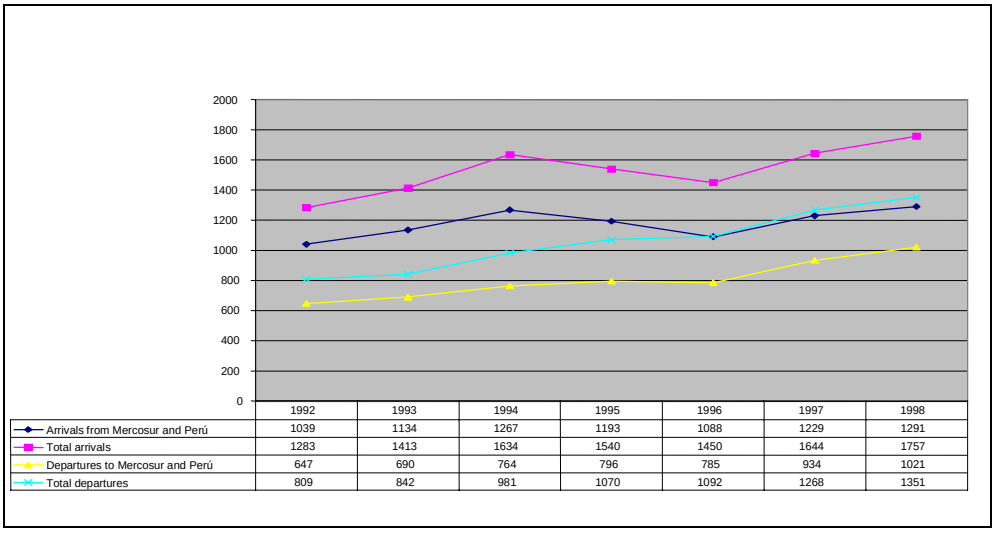
At the organizational level, the development of these products is one of the areas where it would be necessary to change the generally isolated perspective that has evolved in the institutions and companies of the national health system. This would require greater integration between healthcare and activities such as rest homes, physical culture, and tourism, confronting the fear of complicated intersectoral arrangements that we found while conducting this research, even among those who are recognized as the health system's most capable managers. Exposure to the experience of other countries in technology capture missions could be a basic factor in promoting these ideas.

b) Establish Links between Tourism and Health

Always from the perspective of MERCOSUR, although not limited to it, it is desirable to establish links between tourism and activities to expand the delivery of health services to temporary foreign residents (Ashworth and Goodall 1999). In this case, unlike what has been done with foreigners living here for one or more years where we can anticipate a gradual increase although at lower rates than in earlier years, this market segment would consist of tourists. This may involve tourists whose stay in Chile represents an increase in the demand for general healthcare or some tourism product that is based on the country's utilization of comparative advantages and that includes a significant healthcare component.

Figure 6 shows dynamic growth in Chile's tourist activities and the concentration of arrivals and departures in the MERCOSUR subregion and in Peru. A simple estimate based on data prepared by the National Tourism Service, taking into account the evolution of the economies in the tourists' countries of origin (CEPAL, 1999), shows continuing concentration of arrivals in the subregion and increased departures, with the possibility that by the end of the next 5-year period Chile will receive 2.5 million tourists, more than 70% of whom will come from the MERCOSUR countries and from Peru, with an average stay of 12 days (SERNATUR, 1999).

Figure 6
TOURISM IN CHILE-ARRIVALS AND DEPARTURES
(amounts in thousands)



	1992	1993	1994	1995	1996	1997	1998
Arrivals from Mercosur and Perú	1039	1134	1267	1193	1088	1229	1291
Total arrivals	1283	1413	1634	1540	1450	1644	1757
Departures to Mercosur and Perú	647	690	764	796	785	934	1021
Total departures	809	842	981	1070	1092	1268	1351

Source: Elaborado por la Unidad de Estadísticas. Departamento de Planificación-Servicio Nacional de Turismo (SERNATUR).

The importance of this flow of tourisms is not so much that it represents an increase in the demand for health care but rather that while visiting Chile these tourists will have the opportunity to examine the country's healthcare system as a criterion for selecting their destination and ultimately to use its services. The fact that 65% of the tourists who came to Chile in 1988 came from Argentina, Bolivia, and Peru, and these predominantly from border areas, increases the relationship between tourism and health, as already indicated.

In addition, as part of its domestic and international tourism attractions, Chile has traditionally developed thermal baths and spas. It has more than 100 potential sites, and 30 important sites are in operation. Most of these sites are in the early or middle stages of development,

putting Chile in first place in South America for this trade category. This trend in the level of development of thermal baths and spas has begun to turn around as several of the centers are either located in the same place as or are part of facilities providing a higher level of care. However, these centers' only connection with healthcare is the presence of a physician or nurse to attend to occasional health problems. There is potential for adding to this natural attraction and form of recreation a wide range of healthcare services, particularly those designed for the population segment aged 60 and over.

c) Exporting health service in border areas

This is one of the best known health care export products, particularly because there are marked differences between areas, as in the case of northern and central Chile and southern Peru, central and southern Bolivia, and northern Argentina. The border areas of neighboring countries are also distant from metropolitan areas or national capitals, with the exception of Bolivia, which includes the capital; the total population in the nearest border areas is some 10 million inhabitants. In order to better appreciate what development of this product represents, we will briefly analyze the case of northern Chile.

This is the area that has seen the greatest increase in the flow of bilateral trade and tourists and patients from Bolivia over the last two years. This is associated with completion of construction of the international highway joining the Bolivian capital with the capital of the Chilean department of Arica and the main branch of the national highway. At the same time, of all the country's regions it is the northern region of Chile together with the capital that has received the highest percentage of direct foreign investment over the longest period of time. This investment has been concentrated in mining activities. What is of interest to us is that this has led to great investment in productive health centers. These are usually first-rate centers so that they can attract and retain the working population and have significant idle capacity because of the limited size of the target population at present.

The development of this area, in addition to allowing health insurance programs to carry out their role as facilitators of trade, as indicated in Section II, also means that measures must be adopted to fully use the idle capacity of existing high-level centers, expanding their radius of care to populations in neighboring countries and coordinating the activities of general healthcare centers with activities related to occupational health.[4] The exploratory interviews conducted with key people involved in economic and healthcare activities and in local governments in those areas and at the respective national central organizations indicate that people are highly receptive to such proposals.

This border area will experience expansion as a potential health export market with completion of the international highway connecting northern Argentina, eastern Bolivia, and western Brazil (Matto Grosso).

d) International agreements on health insurances

As a customs union and the nucleus of an economic integration agreement, MERCOSUR has specialized commissions, such as the health commission, that have already approved initiatives such as those on the exchange of services between health services cooperatives. An initial further step in that direction would be to negotiate an agreement making it possible to include travel insurance in the health plans of public and private insurers. This would be an additional incentive for tourism within the subregion and would serve to expose tourists to the subregion's health systems. This

[4] Currently Chile has a superior level of development in occupational health for mining activities at high elevations (above 2 000 meters). Such activities are also important in the bordering areas of Bolivia and Peru.

would pave the way, simultaneously or subsequently as applicable, toward agreements allowing access to specialized fields or general medicine in border areas for members of the healthcare systems in one or more member countries.

The combination of social security reforms in health and the establishment of MERCOSUR make this a timely moment for such initiatives. The example of the European Union shows that once the integration processes is consolidated it is more costly to change barriers that have not been removed such as those on trade in health services in the countries of the European Union. In addition, experience in Southeast Asia indicates that insurance companies and health providers in many countries, as already happens in MERCOSUR, are able to play an integrating role that actually promotes subsequent and more general negotiations between countries.

e) Specialized professional and technical training

Acknowledging that the internationalization of professional, academic, and in-service training of specialist teams is a requirement for dynamic evolution, the objective would be to optimize the combination of these training components. In particular, this means obtaining a balance between modernism in training, as measured by the most advanced international level, and maximum development of national capacity for academic and in-service training of specialist teams. Particular attention would be given to the equitable distribution of financing for training among public and private participants, as well as institutional participants and professionals and technicians in private practice.

The principal instruments for achieving these objectives would include international technical cooperation agreements, policies on fellowships and credits for specialized professional and technical training, including strong participation from insurance programs and FONASA and the centers providing services, as well as promotion of specialized training and modernization of health services management, particularly human resources management, in order to improve human resource allocation and utilization in the short and medium term.

Our analysis indicates that internationalization of the Chilean health system, although it has received essential support from advances made in the developed countries, particularly the US and some countries of the European Union such as England and Spain, has found a natural setting in the countries of MERCOSUR and some Latin American countries based on geographic location and traditional academic and professional ties. MERCOSUR seems in particular to be the preferred international arena for carrying out professional training activities.

In the field of the specialized professional and technical training, Chile and the countries more advanced in technology and health training could combine efforts to develop training in short- and medium-term specialties. Far from an approach that would replace imports from the developed countries, we believe that the correct policy approach would be to utilize current ties but direct them toward a broad program of training in subspecialties that would make it possible to satisfy the current unsatisfied demand in MERCOSUR, Chile, and Bolivia more rapidly and at less cost. It would later be possible to compete for professional and technical short- and medium-term training in the South American market and in the markets of some Central American countries.

In the field of professional training, it would be possible at the same time to facilitate the inclusion of top-notch specialists in activities directed to hemispheric integration and integration with the European Union, as well as to promote other activities such as foreign studies programs where Chile already has experience in other disciplines. These activities could promote the national program and specialist training in MERCOSUR.

Progress in the sciences and healthcare in the developed countries and the similarity of central aspects in the demographic and epidemiological evolution of Chile and MERCOSUR means that adaptive incorporation of these aspects is the natural way to modernize the national health

system. However, the dangers of modernizing health systems solely on the basis of imitation include underdevelopment of national research and making modernization and research on development dependent upon third countries. This means that it is possible to strengthen the ties created when national specialists and researchers are trained in developed countries, particularly in the case of joint research on pathologies that are widespread or specific to Chile and the MERCOSUR countries or on common pathologies, where relationships among researchers from various countries make it possible to obtain or disseminate results more rapidly.

In the current phase of negotiations to create free trade systems within the hemisphere and with the European Union, the search for joint initiatives such as professional training and health research would be given preferential attention, either because they do not affect significant commercial interests or because they are of mutual interest and could be seen as symbols of integration and receive support from the countries most advanced in the field of research and from the countries most advanced in the field of professional training and health sciences research such as the countries of the European Union, Canada, and the US.

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