Industry, Science and Technology Canada
Industrie, Sciences et Technologie Canada

FUTURE MARKETS FOR CANADIAN HEALTH CARE SERVICE PROVIDERS

SERVICE INDUSTRIES

Canada

FUTURE MARKETS

FOR CANADIAN HEALTH CARE

SERVICE PROVIDERS

Consulting and Engineering Service Industries Directorate
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Introduction

In 1986, Industry, Science and Technology Canada (then known as the Department of Regional Industrial Expansion) sponsored the Services Industries Study Program (SISP). That two-year research initiative examined the structure and dynamics of the service sector and its component industries.

Three organizations, the Fraser Institute, the Institute for Research on Public Policy and Statistics Canada, undertook separate aspects of the service sector research by commissioning numerous studies on specific service industries, trade in services, horizontal issues and statistical development. In the health field, a paper titled "Caring for Profit: Economic Dimensions of Canada's Health Industry" was published under the auspices of the SISP.

The SISP was a major step on the part of the federal government to understand the rapid growth of the service sector and to lay the foundation for a range of initiatives in support of Canada's future growth and competitiveness. The publication of an industry consultation paper on the SISP in 1989 marked the beginning of the second phase of this effort.

In one element of this consultative phase, Industry, Science and Technology Canada (ISTC) communicated with health care service firms and government departments, including Health and Welfare Canada and External Affairs and International Trade Canada (EAITC), to identify export interests and sector capability. Following these discussions, ISTC circulated in 1992 a draft paper titled "An Assessment of the Export Potential of Canadian Expertise in the Provision of Health Management Services."

This paper follows on from that draft document. Our objective in publishing this substantively revised paper is to disseminate an overview of export market opportunities obtained from a number of sources. It is hoped that this information will assist the private sector and other interested parties, within the preparation of their export strategies, with the identification and evaluation of, and approach to, potential markets for the export of Canadian health care services. Our intent is to continue the dialogue started in 1992, encourage the exchange of views within the health care service sector and promote synergy among stakeholders with a view to an enhanced level of exports.

The Canadian System of Health

Health care is commonly perceived as a life-saving activity and/or as a means of prolonging life. The World Health Organization's guidelines define health care activity as any output where both the major intent and effect is to improve the quantity and/or quality of people's lives as well as any output produced by a worker defined as a health care professional.

On the domestic front, the *Canada Health Act* of 1984 stipulates that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada, and to facilitate reasonable access to health services without financial or other barriers. With constitutional authority for health care delivery resting with the provinces, our system is made up of interlocking provincial health plans. The federal government sets basic standards and contributes financially to the operation of the provincial plans.

This taxpayer-financed, comprehensive health care system covers hospital and doctors' services for all residents, regardless of ability to pay. The sector is unique in that many of the nation's health care assets are community or privately owned but the services they provide are largely funded by the public sector. As well, much of the expertise associated with the design and operation of the health system resides in the public sector.

The excellence of Canada's system of health care is recognized worldwide. The *World Competitiveness Report 1991* states that "ultimately, the competitiveness of a country, or enterprise, rests on the abilities and skills of its people." Canada was ranked first in the world for the "quality and availability of health care to employees and their families."

In 1991, health care spending in Canada totalled an estimated US$56.9 billion (C$66.8 billion). Canada spent US$2 110 per capita for health care in 1991 (C$2 474) while the United States spent $2 817, about 34 percent more. In 1971, Canada and the United States were spending about the same percentage of their gross domestic product (GDP) on health care, 7.5 percent and 7.6 percent, respectively. By 1991, the share of Canada's GDP spent on health care had risen to 9.9 percent, while U.S. spending was projected to reach 13 percent. This Canadian performance is attributed, in part, to an efficient public administration in the health services sector.

Canadian Supply Capability

The scientific, technological, social and economic progress of the past 50 years brought many changes to the Canadian health care system. Research resulted in the introduction of new drugs, and sophisticated new diagnostic and treatment tools became available. In the 1950s, costs rose more dramatically, and the need for capital outran the resources of the philanthropic and voluntary sector that had been associated with health care for years. As a result, the role of government expanded rapidly.

By 1988, health care had become one of the largest service sectors in the Canadian economy. It employed approximately 530 000 people, and an estimated 350 000 additional people derived most of their income from it. Between 1984 and 1991, an estimated 128 400 jobs were created in the health services sector.[1]

Although many health care service providers are funded directly by government, a vital private sector health services industry in Canada provides a wide array of services including operational management to health care institutions, consulting in technical specialities to management and government, nursing and long term care, design and construction of health care facilities, and clinical laboratory services.

This private sector health services industry consists of a number of large and medium-sized firms and numerous small companies and sole practitioners, the majority of which are domestically oriented and controlled. There are also several firms oriented to the export market that have achieved success in that arena. A few firms — the management consulting practices of the large international accounting firms being an example — maintain international affiliations. Many of the health service firms maintain alliances with appropriate resource personnel so that they can draw on them as needed.

Industry practitioners are generally located in large metropolitan centres and, by virtue of demographics, are concentrated in the provinces of Ontario, Quebec and British Columbia. Influences on the location of service firms include the presence of research and development facilities, universities, teaching hospitals and federal and provincial health ministries.

A summary of the sector's areas of strength, as known to ISTC, is provided below.

- comprehensive management services
- consulting services in a wide range of specialities
- management information system (MIS)
- home health care
- medical and surgical procedures
- health care insurance
- health care policies and systems
- management and operation of long term care facilities
- staff development, training and teaching
- education
- medical and testing laboratories
- research and development and transfer of technology
- design and construction
- professional recruitment
- environmental services
- public and occupational health
- disaster and emergency preparedness
- preventative primary health care in remote regions.

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[1] *Globe and Mail*, "The Rising Value of Brain Power," 1 September 1992.

The International Demand for Health Care Services

Financing Health Care Markets: The International Financial Institutions

Opportunities for Canadian health care service providers lie in both the developed and developing countries. There are significant differences in the health care needs of each market, and these differences extend to the source of project funding. In developed countries, health care expenditures are generally funded internally by governments or the private sector while, in developing countries, funding for health and other development projects is largely obtained through loans or grants from the World Bank and other international financial institutions (IFIs).

The World Bank, which consists of the International Bank for Reconstruction and Development (IBRD) and the International Development Association (IDA), and the regional IFIs, such as the Asian Development Bank, Caribbean Development Bank, Inter-American Development Bank and the African Development Bank, have similar mandates to promote the economic and social progress of developing member countries. Although the World Bank is perhaps the best known of the IFIs (it is the institution referred to most often in this report), the regional development banks should not be overlooked.

These regional development banks are often able to mobilize additional resources within their region and attract additional investment from outside. Many times these institutions are able to finance projects either not financed or inadequately financed by existing national and international agencies. They are in a unique position to address the needs of the smaller of the less developed nations within the "developing countries" sphere.

The World Bank has been widening its focus on Human Resource Development (HRD) to the point that concerns about education, health, nutrition, population, training and the role of women in development are apparent in all aspects of its development activities. The World Bank's increasing focus on health is evident in the fact that its World Development Report 1993 is to be titled "Investing in Health."

This focus is also evident in the World Bank's project approvals. Projects relating to health care, population and social development have represented a greater share of its budget allocations in recent years. During the period 1983 to 1987, for example, the World Bank's annual average lending to the population, health and nutrition (PHN) sector was US$205 million. In fiscal year 1992, it approved lending of US$962 million, a most substantial increase over those earlier years and above a commitment made in 1991 of an annual minimum of US$800 million. Lending for PHN projects is now hovering in the range of 4 to 5 percent of total Bank lending, up from the average 2 percent of lending experienced in the early 1980s. This trend is no doubt similar in other IFIs.

In the global context, IFI activity within the PHN sector varies. Generally speaking, the emphasis is on the development of preventive and health promotion programs, public health programs and primary health care systems in the poorest countries. For example, the World Bank's activity has

increased in the population sector. Africa is the principal beneficiary of loans centring on family planning. On the health front, there has been some movement away from primary health care projects to those involving policy formulation, program planning and management. Disease eradication is still high on the Bank's list of priorities. Nutrition continues to be a focus of adjustment lending, increasing almost tenfold during the 1988-91 period compared with the preceding four-year period.

Table 1 summarizes the $6 billion in health care project proposals currently in the IFI pipeline. On the basis of an approximate two-year lead time from the project definition stage to project implementation, it can be assumed that projects valued at US$3 billion will come on stream annually.

It must be remembered that, for the most part, consultants are selected by the beneficiary country and not by the IFI itself. As consultants' services are usually required in early stages of a project, it is necessary for these firms to identify and target beneficiary countries at an early stage to assist them during the definitive, preparatory phases of a project.

A Global Perspective

Improvements in health constitute an investment in human capital and social development aimed at improving the quality of life. This undoubtedly leads to future yields in terms of increased productivity and lengthened life expectancy, among other beneficial results. In addition, better health, it has been noted, brings substantial economic benefits by releasing resources that can be used to achieve other development objectives.

Developing countries face numerous challenges in the area of health and the issues are defined by the health scheme in place. Many of the developing countries of the world have health care priorities different from those of Canada. Although there may be some elements in common with western health systems, such countries often lack the infrastructure and human resources to provide a full range of services, and rarely lack only one aspect of a health care system. What often is needed is institutional strengthening and the necessary infrastructure, personnel, and national programs for population, health and nutrition services, with particular emphasis on the provision and expansion of primary and preventive health care.

While health programs may exist in one form or another in the developing world, serious problems need to be overcome in the quality, effectiveness and efficiency of the service. The challenges lie in helping these countries develop institutional capacity, the resource base and the distribution network to improve on what is already in place. The developing countries most often need the financial support provided by the IFIs and aid organizations to improve their systems through technology and knowledge transfers enabling them to move forward more independently.

In an effort to more closely focus on specific areas of opportunity for service providers, information was obtained from a number of Canada's trade posts and other sources. A summary of the more prevalent export opportunities, with a corresponding market description and possible sourcing linkages to which they give rise, is set out in Table 2.

Table 1 Anticipated Value of Project Proposals Currently under Consideration by the Leading IFIs [1] (US$ millions)

Region	Middle-income countries	Lower-income countries	The poorest countries	Total	Percentage of total anticipated projects	Percentage of projects approved in past two years[2]
Africa		128	513	641	11	16
East Asia	97	288	310	695	24	35
South Asia			692	692		
Eastern Europe	639			639	23	16
Western Europe	350			350		
Arab Countries	125	210		335		
Caribbean	170	122	90	382	42	33
Latin America	1 683	423		2 106		
Total	3 064	1 171	1 605	5 840[3]		
Percentage of total anticipated projects	53	20	27	100	100	100

[1] IBRD, ADB, AfDB, IDB, August/September 1992.

[2] "Strategy for Marketing Healthcare Resources," Ontario International Corporation, February 1992.

[3]Potentially equivalent to approximately US$ 3 billion per year, assuming projects take an average of two years to gain approval.

Table 2 Summary of More Prevalent Opportunities

Market description	Vital signs	Typical countries		More prevalent project opportunities	Possible sourcing of canadian expertise
Higher- income countries	GNP/cap> $15 000 Pop/doc < 750 Pop/bed < 200	North America Asia	U.S. Japan, Singapore	Sector financing Long-term care facilities for the aged	Private firms in collaboration with provincial MoHs Private facility management companies
		Oil-exporting countries	Saudi Arabia	Hospital construction Hospital staffing/mgmnt Personnel training	Private firms Private firms and/or hospitals Private firms and/or community colleges
Middle- income countries (in general)	GNP > $1 500	Most middle-income countries in the developing world		Sector planning and management, often with a focus on financing and/or decentralization Construction and rehabilitation of hospitals and primary care facilities Personnel training Public health/wellness	Private firms/prov MoH/ universities Private firms Private firms and/or community colleges Private firms/NGOs/universities
Plus additional special needs: • with substantial infrastructure and trained personnel in place	Pop/doc < 1 000 Pop/bed < 300	Eastern Europe Latin America Caribbean	Hungary, Poland Romania Greece, Israel Argentina Venezuela Costa Rica Bahamas Barbados, Trinidad	Plus: Management of primary care programs Hospital management Management information systems	 Private firms/prov MoH/ HSOs/NGOs Private firms and/or hospitals Private firms and/or hospitals

Table 2 Summary of More Prevalent Opportunities (concluded)

Market description	Vital signs	Typical countries		More prevalent project opportunities	Possible sourcing of canadian expertise
• with less infrastructure and trained personnel	Pop/doc > 1 000 Pop/bed > 300	Asia Arab countries Europe Latin America	Korea, Malaysia Algeria, Iran Albania, Turkey Brazil, Chile Mexico	Drug manufacture and/or supply, regulation and distribution Laboratory construction and/or rehabilitation and management	Private firms in collaboration with provincial MoH Private laboratories
• with a growing 1elderly population		Asia Caribbean	Korea Bahamas Barbados	Long-term care facilities for the aged and infirm	Private facility management companies
Lower-income countries	GNP$500 to 1 500 Pop/doc > 1 000 Pop/bed > 300	Africa Arab countries Asia Latin America Caribbean	Angola, Nigeria Zimbabwe Egypt, Jordan Morocco Indonesia Philippines Colombia Guatemala, Peru Guyana Jamaica	Primary care program delivery Public health/wellness Rehabilitation of infrastructure Sector planning/ management, with an occasional focus on financing Personnel training	Private firms/prov MoH/ HSOs/NGOs Private firms/NGOs/ Universities Private firms Private firms/prov MoH/ Universities Private firms/community colleges
The poorest countries	GNP < $500 Pop/doc > 2 000 Pop/bed > 800	Africa Asia Caribbean	Burkina Faso Mozambique Laos, Pakistan Haiti	Public health/wellness Sector planning/ management, with occasional focus on decentralization Rehabilitation	Private firms/NGOs/ Universities Private firms/universities Private firms

A growing share of IFI resources are being invested in the development of primary health care infrastructure in the world's poorest and lower-income countries. The poorest countries, generally those with a per capita gross national product (GNP) of less than US$500, have basic needs such as public health/wellness programs, the rehabilitation of existing infrastructure and, to some extent, assistance with sector planning and management. The lower-income countries, those with a GNP of between US$500 and $1 500, have similar needs, but there are also demands for service providers in primary care program delivery and in the training of health care personnel.

The middle-income countries, those with a GNP in excess of US$1 500 offer a slightly different mix of opportunities. Generally speaking, most of these countries need sector planning and management services, personnel training, rehabilitation and, to a lesser extent, construction of hospitals and primary care facilities as well as public health and wellness programs.

However, within this general middle-income country classification, distinct subcategories may have particular needs. In countries with substantial health care infrastructure and trained health care personnel in place, opportunities for providers of management information systems, hospital management services and management of primary care programs exist. Those middle-income countries with less infrastructure would likely offer opportunities for those in the health policy and laboratory fields. Those middle-income countries with an aging population base would clearly offer opportunities for providers of long-term care services.

The priorities of higher-income developed countries, those with a GNP in excess of US$15 000, are likely to centre on sector financing issues such as cost containment and long-term care facilities. The building and operating of turnkey private or public hospitals are likely to be limited in all but the oil-exporting countries due to the high capital and operating costs associated with such institutions.

By reason of their level of economic development, the higher-income countries are not entitled to IFI funding. They usually have a functioning health care system and, for many, the principal issues relate to cost containment, resource optimization and health care funding. This presents opportunities for the development and implementation of insurance plans and organizational and managerial services associated with large prepaid medical systems similar to those operated by the provincial health insurance plans. Included would be emergency health care systems and computer information systems for patient care, billing and hospital administration, and state of the art technology.

These global opportunities are varied, and the full range of perceived needs and demands cannot possibly be filled by any one firm. As well, many of the opportunities contain a requirement for elements of expertise often resident in the public sector. This points to an opportunity for public and private sector collaboration in the pursuit of export opportunities. Table 3, which builds on the last column of Table 2, suggests possible groupings of Canadian expertise to meet the needs identified in IFI projects.

It should be noted that competition for IFI-funded professional services projects is keen and is invariably strong from the United States and the United Kingdom. Other European countries, most notably France, Germany, Sweden and Austria, are active in the field as well. In response to a questionnaire used in a study prepared for the Ontario International Corporation, Ontario health care

Table 3 Possible Sourcing of Canadian Expertise

Identified needs/opportunities (ranked in accordance with frequency of reference)	Possible sourcing of required skills and experience
Sector planning and organization	Management consultants, in collaboration with provincial MoHs
• with particular reference to financing	Benefits consultants, in collaboration with provincial MoHs and/or private health insurance companies
• with particular reference to decentralization	Management consultants, in collaboration with provincial MoHs, hospitals and/or hospital associations
Personnel training for • management • paramedics • nurses • technical specialists	Training consultants and/or community colleges
Construction and/or rehabilitation of • hospitals • primary care facilities • research institutes • laboratories • training facilities	Architects, engineering consultants, project management firms, procurement specialists
Hospital management	Management consultants, in collaboration with hospitals and/or hospital associations
Management of primary care programs	Management consultants in collaboration with HSOs, NGOs
Management information systems	MIS consultants in collaboration with provincial MoHs, hospitals and/or hospital associations
The management of long-term care facilities for the aged and infirm	Private facility management companies
The regulation and distribution of drugs	Management consultants in association with provincial MoHs
The specification and management of emergency health services	Management consultants in association with provincial MoHs
The design and management of public health/wellness programs	Management consultants in collaboration with Health and Welfare Canada, with NGOs and universities

service providers identified their principal competitors as firms from the United States, the United Kingdom, France and Germany. It should be noted that Switzerland and Japan also provide competition for Canada's service providers.

Regional Markets

The following portion of the paper provides a short narrative on the regional market opportunities distilled from the information provided by Canada's foreign trade posts and that available from the IFIs. As well, insight into the objectives and activities of several of the development banks as gleaned from their annual reports, is also provided.

The developing countries entitled to assistance from the IFIs perhaps offer the greatest source of contract opportunities for Canada's health care service providers. In addition, there is a market for health care services in the industrialized and oil-exporting countries, most notably Saudi Arabia.

Table 4 provides an overview of these regional opportunities and a possible focus for Canadian export efforts.

Africa

Headquartered in Abidjan, Côte d'Ivoire, the African Development Bank (ADB) is active in assisting its developing member countries improve their economies. The health sector is one of the ADB's priority lending sectors and, for the period 1993 to 1995, the Bank is considering funding health related projects valued at approximately US$320 million. Its proposed program includes projects in hospital rehabilitation, health studies and rebuilding of health infrastructure.

Also active in the region is the World Bank, which has characterized Africa as a continent in transition. As in other geographical areas, the World Bank is giving priority to social-sector development, and increasing activity is evident in poverty reduction projects.

Population growth in Africa continues to pose problems in terms of political instability and economic development. Toward this end, the World Bank is working to reduce the rate of population growth to levels that will support economic growth, and is preparing African women for a larger role in development by improving their access to the means of production and to improved educational and health services.

The needs across Africa for health care services are not uniform, and vary with the economies of individual countries. These markets offer a long-range opportunity for Canadian firms, primarily for consulting firms to aid in the initial stages of health care planning and program development. Lower-income countries such as the Cameroon are focusing on strengthening their financial and human resource management programs while others, including Angola, Botswana and Lesotho, are developing projects focusing on health care worker training, improving health institutions and rural

Table 4 Possible Focus of Marketing Activity by Region

Region		Indicative proportion of IFI market[1]	Prevalent service opportunities	Typically with focus on:	Principal competitors
Africa	Lower-income countries	2%	Personnel planning/training Primary care	Management; paramedics; nurses; technical specialists Management of program delivery	
	Poorest countries	9%	Sector planning and organization Facilities rehabilitation Public health/wellness	Policy formulation and analysis Effective sector management Decentralization Hospitals and primary care facilities Nutrition and mother/child programs	
East Asia	Higher-income countries	Not eligible for IFI support	Facilities management	Development and management of long term care facilities	U.S.
	Middle-income countries	2%	Sector planning and organization Financing Personnel planning/training	Policy formulation and analysis Health insurance plans Management; paramedics; nurses; technical specialists	Austrian British Japanese Swedish
	Lower-income/ poorest countries	10%	Primary care Public health/wellness	Management of program delivery Mother/child and educational/ promotional programs	British, U.S. German Japanese
South Asia	All countries	12%	Sector planning and organization Financing Primary care Public health/wellness	Effective sector management Financial analysis Mother/child and disease control programs Management of program delivery	
Europe	Middle-income countries (Eastern Europe and eastern Mediteranean)	17%	Sector planning and organization Financing Personnel planning/training Primary care Facilities management Systems management	Effective sector management Decentralization Health insurance plans Management Program planning and delivery Hospitals, long-term care facilities Management information systems	
Arab countries	Oil-exporting countries	Not eligible for IFI support (foreign exchange content of Saudi budget equivalent to 20% of IFI market)	Personnel planning/training Construction/rehabilitation of facilities Hospital management	Paramedics and technical specialists Construction of new hospitals and primary care faciliites "Turnkey" staffing and management	 U.K. and U.S. hospitals

Table 4 Possible Focus of Marketing Activity by Region (concluded)

Region		Indicative proportion of IFI market[1]	Prevalent service opportunities	Typically with focus on:	Principal competitors
Arab countries (continued)	Middle- and lower-income countries	6%	Primary care Facilities construction/rehabilitation Systems management	Program planning and delivery Hospitals and primary care facilities Regulation and distribution of drugs	France Germany Switzerland
Caribbean	Middle-income countries	3%	Personnel planning/training Facilities construction/rehabilitation Systems management	Management, paramedics, nurses and technical specialists Construction of new hospitals, long term care facilities and training establishment Management information systems	U.S.
	Lower-income/ poorest countries	4%	Sector planning and organization Primary care Facilities construction/rehabilitation	Effective sector management Program planning and delivery Rehabilitation of primary care facilities	
Latin America	Middle-income countries	28%	Sector planning and organization Financing Primary care Facilities construction/rehabilitation Public health/wellness	Policy formulation and analysis Effective sector management Health Insurance plans Program planning and delivery New and rehabilitated hospitals, primary care facilities and laboratories Mother/child programs	U.S.
	Lower-income countries	7%	Primary care Facilities construction/rehabilitation Public health/wellness	Program planning and delivery Rehabilitation of primary care facilities Nutrition programs	U.S., France Germany
North America	U.S.	Not eligible for IFI support	Sector planning and organization Financing Facilities management Primary care	Geriatrics, HIV Health care insurance plans Cost containment programs Departmental management in hospitals Rural health care	

[1] See Table 1.

[2] Based on replies received from Embassies and High Commissions and on recent contract awards.

health services. Many of the low-income countries are still primary care-oriented and are concerned with disease eradication and improving their existing health systems.

Middle East (Arab and Oil-producing Countries)

Canadian health care practitioners and service firms have been providing services to countries in the Middle East, principally Kuwait, the United Arab Emirates and Saudi Arabia, for a number of years. These markets, fuelled by oil revenues and the concomitant increase in economic growth, created opportunities for health care professionals, health care management and management consulting firms. In addition, professional recruitment firms are participating in the market. Although the growth in opportunities has slowed in the region, the expected growth in these countries' economies, and the need to rebuild infrastructure in Kuwait, might present opportunities for Canadian providers of services.

The subsidization by Egypt of many of its medical services will continue, and the country's population explosion will result in opportunities. Saudi Arabia's current five-year health plan may also offer service providers opportunities in areas such as primary and preventive health care services and upgrading of hospital services. Morocco's intention to improve many aspects of its existing health care system could provide prospects for Canadian service firms. Several needs have been identified, including human resource management and primary health care.

Europe

The movement to market economies in many eastern European countries and countries of the former Soviet Union will bring about a demand for more modern facilities particularly as these countries focus on raising their health care standards to international levels. Although opportunities in the area of public health operations and infrastructure currently exist in many of these countries, these are not large-scale operations. In addition to the lack of hard currencies in these countries, market access will remain difficult and will likely necessitate technology transfer. A commercial presence or joint venture arrangement with a local firm will likely be a requirement for any Canadian participation.

The continuing disintegration of the hospital supply system in the Czech Republic and the Slovak Federal Republic could lead to its eventual collapse. This would mean possible opportunities for western firms in both medical supplies distribution and hospital/health care institution management and administration. The principal need in the Czech Republic centres on primary health care. However, health care has not been identified as a priority by the government, and this leaves IFI participation questionable.

In Hungary, a project is under way to restructure the health sector and, in Romania, an urgent project on the rehabilitation of the health sector is being developed.

The high-income countries of western Europe are encountering problems similar to those in North America. Opportunities exist for health care service providers as interest grows in North American

technology and expertise. As well, as the population ages, opportunities have been identified for the long-term care sector.

Latin America and the Caribbean

Latin America and the Caribbean offer additional opportunities. Canadian firms have used Canadian International Development Agency (CIDA) funds to pursue health care projects in several countries. The difficulty in pursuing perceived opportunities within these markets is the high level of inflation, uncertainties over project financing in view of the debt burden on national governments, and foreign exchange controls.

Although the Caribbean Development bank does not have health care projects on stream or in its pipeline, the Inter-American Development Bank (IDB) is active in Central and South America accelerating the economic and social development of the region. Thirty years ago, the bank was a pioneer in financing social projects and, while its operations cover the entire spectrum of economic development, particular emphasis remains on the social sectors of health and education.

Since inception, the IDB has directed US$5 000 million to the environmental and public health sectors. In 1991, it approved US$407 million for projects in the health sector. Overall social lending totalled US$988 million. Uruguay benefited from IDB funding for services in the areas of education, health, nutrition and care for the elderly. El Salvador, Nicaragua and Peru also received funding for the establishment and implementation of social emergency funds. A recent loan to Bolivia will finance an integrated health program for rural and urban districts in the interior of the country. Such opportunities will persist as the IDB continues to meet growing social sector demands by financing broad based programs.

In the lower-income countries of the region such as Guatemala, Colombia, Ecuador and Honduras, the emphasis of IFI activity appears to be on the development of programs to strengthen existing health services and nutrition programs.

United States

The United States market is the largest and presents the greatest potential for Canadian health care service firms. Due to its proximity to Canada, common language and similar cultural and business environments, it is an easier market to research than many distant venues. Opportunities exist in many fields. Technical expertise gained by the private sector in association with provincial health insurance schemes can be marketed to the state level and to operators/organizers of prepaid health schemes. Expertise in programs and systems for cost containment and data management have been indicated as a need. This could possibly give rise to Canadian public and private sector alliances.

Asia (including South Asia)

Based in Manila, the Asian Development Bank (ADB) is the regions counterpart to the World Bank. Health services in many member countries of this regional IFI have suffered over the years from a lack of essential planning and a shortage of staff trained in management and administration. As with many IFIs, the ADB has begun focusing its operations on primary health care through preventive programs aimed particularly at the needs of the region's poor. The ADB is recognizing that a more cost-effective, equitable and efficient allocation of health resources for preventative programs is needed. Toward this end, it will be encouraging the coordination of public and private services to ensure the efficient operation of existing and planned health referral networks.

The World Bank is also active in the region. It is working with the Government of Vietnam in preparing sector studies on population, health and nutrition. However, the bulk of the Bank's lending operations are concentrated in China, Indonesia and the Philippines. In view of their economic progress, many countries of the region are no longer entitled to borrow from the Bank. Korea, for example, will no longer be eligible for assistance after 1995. Leading up to that date, it will likely concentrate on the social sectors, social infrastructure and other areas that have been neglected. Specifically, there are opportunities for training in hospital management services and information systems development in the Korean hospital sector. In Malaysia, the focus is on the construction and upgrading of existing health care facilities. Similarly, in Indonesia, the need appears to lie in the construction of physical facilities and personnel training. Several projects are being developed in the country's community health field.

Thailand is looking at improving its emergency medical systems, while institutional strengthening, community health development and family planning are important needs in the Philippines.

Shifting to the poorer countries of the region, many have development projects under consideration. Projects in countries such as Laos, India and Pakistan generally pertain to disease eradication, nutrition, family planning and/or improvements in basic health care.

The Canadian Consulate General in Osaka recently completed a marketing study on "Products for the Elderly". The report found that Japan continues to boast the world's highest life expectancy. Of the current population of 124 million, one out of every eight persons is over 65 years of age. Twenty years from now, one out of every four people in Japan will be over 65!

The need for long-term care facilities and services directed toward the elderly is increasing rapidly. The seniors market is perhaps the single largest market in the country and is estimated to approach $975 billion by the year 2000.

Summary of Regional Opportunities

Table 5 complements Table 4 and the foregoing narrative, and provides information respecting the possible focus of marketing activities on a functional basis. Given the number of years it can take for

Table 5 Possible Focus of Marketing Activities by Function [1]

Services	Anticipated level of opportunity [2]	With focus on:	Examples of possible grouping of expertise	With provincial MoH support	Target markets
Sector planning and organization	frequent	Policy formulation and analysis Effective sector management Decentralization Cost containment thru wellness	Management consultants University-based health economists	Senior management Policy analysts	Africa Latin America Specific countries in the Caribbean and Asia
Financing	occasional	Health care funding Extended care funding Data management and info systems	Management consultants Benefits consultants MIS consultants Private health insurance companies	Health insurance managers and analysts	Europe (middle income) Specific countries in Asia, Latin America and the Caribbean
Personnel planning/ training	frequent	Health care sector management Hospital management Primary care program mgt. Paramedics/nurses/ technicians	Training consultants Provincial hospitals/ associations Community colleges	"On the job" experience	Africa (lower income) Asia Europe the Caribbean Specific countries in Latin America
Primary care	frequent	Program planning Management of program delivery Health research	Management consultants NGOs Universities	Community care/health service organizations	Europe Lower-income countries in East Asia, the Caribbean and Latin America
Facilities construction/ rehabilitation	construction = occasional rehabilitation = frequent	Hospitals Clinics Research Institutes Laboratories Training facilities	Architects Consulting engineers/project managers Procurement specialists		New construction in: • Saudi Arabia • Middle-income countries in Latin America and the Caribbean Rehabilitation in: • Latin America and the Caribbean • Eastern Europe • Low-income countries in Africa

Table 5 Possible Focus of Marketing Activities by Function (concluded)

Services	Anticipated level of opportunity [2]	With focus on:	Examples of possible grouping of expertise	With provincial MoH support	Target markets
Facilities management	frequent	Hospitals District health centres Long-term care facilities	Management consultants Provincial hospitals/ associations Facility management companies		Europe (middle income) Specific countries in Asia and Latin America
Systems management	drugs and MIS = occasional emergency = limited	Drug supply and distribution Information systems Emergency services	Management consultants MIS consultants	Drug program administration Emergency services	Drugs: Africa, Arab countries, specific Latin American (middle income) Emergency: isolated prospects Info systems: Europe, Caribbean
Public health/wellness	frequent	Effective implementation Health research	Management consultants NGOs Universities		Africa (poorest), Europe (middle income), Latin America, the Caribbean, specific Arab countries

[1] Additional information can be found by reference to the various monthly reports (operational summaries or business opportunity reports) published by the various IFIs.

[2] Based on frequency of reference to stated type of services in August/September 1992 Operational Summaries of Proposed Projects.

projects to come to fruition, such an approach would not leave firms dependent on the vagaries of any one market.

Constraints to the Export of Canadian Health Care Services

Based on a review of comments submitted in response to ISTC's earlier draft discussion paper and on subsequent conversations with sector firms and organizations, the following have been identified as some of the more important constraints to the export of Canadian health care services.

Fragmentation. The sector comprises public and private sector organizations. Although many private sector firms offer health care services, few specialize in the field. Linkages must be established with provincial health ministries and other specialists if service providers hope to carry out more than the initial aspects of many projects. Existing fragmentation may limit individual service providers to a functional focus when examining export markets.

In addition, there are numerous health associations, none of which are private sector-oriented nor function to promote Canadian expertise abroad or identify market opportunities for the industry.

Lack of coherent strategy. The sector does not have a coherent strategy to promote and market its expertise internationally but rather tends to respond on an ad hoc basis to export opportunities.

Size of firms and limited resources. The majority of private sector health care services suppliers are small and medium-sized firms with limited resources, whose activities and marketing efforts are primarily oriented toward the domestic market. There is strong competition within this milieu.

Lack of export experience. Many firms in the health services sector do not have significant export experience. Considerable effort and commitment are required to develop the requisite outlook and orientation, particularly in markets other than the United States. Exporting must be considered as a planned activity within an overall business plan, not as an alternative to be considered only when there is a downturn in the domestic market.

Foreign market distinctiveness. The particular characteristics of target markets can pose constraints or impediments to export performance. Local traditions, business practices and legislation differ from country to country. The funding of health care by governments enables them to exercise a strong political influence in the awarding of contracts that foreign professionals must overcome either through extremely high professional and technical qualifications or through local joint venture arrangements.

While flexibility, patience and adequate resources are required when exploring export markets, Canadians can compete on the basis of quality, though as relative newcomers to the export game they often lose to the more experienced exporters from the United States and Europe. Success often requires reliance on the expertise and reputation of local agents and representatives.

Lack of market intelligence. Specific, reliable and timely information on market opportunities and the activities of foreign competition is crucial for potential exporters to develop an active presence in export markets. Since many Canadian firms are small, they often lack the financial resources and personnel to undertake market research. As well, EAITC does not always have the financial and human resources necessary to provide detailed monitoring of all trade opportunities for all industry sectors. In view of supply side fragmentation in Canada, it is difficult for ISTC to identify and monitor industry capabilities and interests.

Competitive prices. Even where Canadian firms would be interested in supplying their services abroad, it must be demonstrated that they would be competitive in the international market. Although Canadian companies are generally in a position to supply quality and even superior health services, their costs tend to be prohibitive, due to domestic factors such as high salary levels. Foreign clientele, particularly in recessionary times, may prefer services of lesser quality at more reasonable prices.

In non-IFI projects, American, British, Korean and other suppliers have learned with experience that the value of tenders is often the key factor considered by local governments or other purchasers in their allocation of contracts. In this context, those suppliers do not hesitate to recruit and utilize lower-quality expertise and services available at cheaper prices to fulfil part of these contracts, filling only the top managerial positions with their more highly paid nationals. Networking, information sharing and international alliances are factors contributing to the success of these firms.

Competition. The foreign markets in which Canadian suppliers often express interest are primarily the developed countries such as Saudi Arabia and the United States and, for long-term care providers, Japan. The developing countries of interest include those with access to relatively large sources of capital, such as the Gulf or Pacific Rim countries, where a health care infrastructure already exits. However, the services offered by Canadian firms are in many cases already available in these markets, either supplied domestically or by foreign firms represented or well established locally. Penetration of these markets is very difficult and resource-consuming, as preference is normally given to local suppliers, when available, or to traditional foreign suppliers with a long-standing presence in the market. To gain a foothold in the market, it is extremely important to be associated with a known local entity.

International reputation. Although Canada benefits from an excellent reputation for its health care system, little is known in many parts of the world about private sector expertise in the supply of health care services. Furthermore, there appears to be a perception on the part of some foreign buyers that the United States is the forerunner in the field of health care and that U.S. companies offer better products and services than do the Canadian firms. While this is not factual, it constitutes an important constraint to the development of Canada's export potential.

Foreign influence within IFIs. Concern has been expressed that the American influence is very strong in many development banks, and beneficiary countries expressing interest in the Canadian health care model and services may be indirectly influenced in favour of the American system. Industry perceptions about a low-profile Canadian image highlights a need to consider a stronger marketing effort to promote Canadian expertise abroad.

Foreign governments' support to their private sector. Another issue of direct relevance to the ability of Canadian suppliers to achieve success in the export market concerns the public sector support available to foreign suppliers. Many developed countries have well-established systems of health care and the necessary supporting infrastructure. Their industry's export efforts may be financially supported by their governments' initiatives aimed at promoting exports. Canada's capacity to financially support export efforts is constrained by budgetary considerations. Nor has it been Canadian practice to match subsidies foreign competitors may receive in support of efforts to capture particularly important contracts as a means of solidifying entry into or maintaining position in a market.

Dilemma faced by publicly financed institutions. Publicly financed institutions have shown interest in exporting their expertise and offering management services abroad. However, such initiatives may give rise to competition among hospitals or between hospitals or other public sector institutions and private sector firms for contract awards.

Conclusion

Very substantial amounts of money are being spent on health care worldwide. Many developing countries are in need of basic systems of health and other aspects of health care, and Canada has the expertise to assist many of these countries. The challenge is to satisfy this demand with Canadian services. Export markets offer experienced firms and institutions with competitive advantages the potential for growth and the opportunity to become less dependent upon the domestic market. Innovative approaches, continuing commitments and sustained efforts will be required to successfully penetrate these markets.

Few sector firms have the critical mass and financial resources to continually market their services abroad. Increased cooperation and collaboration between the private sector and public sector, including its publicly funded health care institutions, must be encouraged to enable the offering of a slate of services of sufficient breadth and depth to respond to the full range of client needs. ISTC can facilitate the effective marketing of the sector by advising on emerging opportunities, encouraging the grouping of resources and selective, non-competitive responses, cooperating with EAITC and its trade posts, and with provincial governments and their agencies to ensure that firms enjoy timely support in pursuing identified opportunities.

While ISTC has initiated the dialogue and can continue the process as outlined above, the private sector must take the lead in aggressive pursuit of foreign market opportunities. Those Canadian service providers who are willing and able to make the necessary adjustments and meet the challenges offered by the international market stand an excellent chance for profitable ventures.