

Trade in health services and GATS in the Sultanate of Oman

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Introduction

The Sultanate of Oman is classified as an upper-middle income country by the World Bank, with an annual per capita national income ranging between US\$ 764 and US\$ 9205. The Sultanate has a population of 2,331,391 of which 1,779,318 are Omanis. Of the population, 41.2% are under 15 years of age and more than 70% live in urban areas.

The public health sector in Oman is well funded, well equipped and efficient. However, the experience of introducing competition has shown that the private sector can fill gaps by providing specialized services. At the same time, sections of the population that want exclusive services and have the capacity to pay would benefit from private health services.

Oman is a member of the Gulf Cooperative Council (GCC), which includes, in addition to Oman, Saudi Arabia, Bahrain, Kuwait, Qatar and the United Arab Emirates among its members. The GCC countries had signed a Unified Economic Agreement in November 1981 and established a free-trade area among themselves in 1983. The GCC free-trade area was transferred into a custom union effective January 2003. This union also covers the services sector, trade and investment.

Oman has also entered into many bilateral trade and economic agreements with a number of Arab and non-Arab countries which include Jordan, Tunisia, Syria, Iraq, Morocco, Islamic Republic of Iran, Pakistan, Turkey, India, Australia, Ukraine, Portugal, the UK, Thailand and Russia. These agreements, however, are of a general goodwill nature based on MFN treatment. They do not cover the services trade and investment.

As a recently acceded member to the WTO in November 2000, Oman's position on multilateral trade liberalization of services under GATS has led to extensive commitments in the services sector, going even beyond the commitments undertaken by developed countries in some cases. Oman made commitments scheduled and bound in 10 sectors and about 100 subsectors of services including all major and sensitive sectors such as professional services, banking and financial services, insurance services, telecom services, distribution services, audiovisual services and transport services. Oman has also agreed to allow branches of either foreign companies or wholly foreign-owned subsidiaries in six sectors. Hence, there are very few market access (up to 70% foreign equity participation allowed in most sectors) and national treatment limitations in Oman's schedule. Oman did not make any further commitments on services in the Doha round. The country may either not submit an offer or submit only a token offer after assessing the level of commitment that other WTO members are willing to make during this round of multilateral trade negotiations.

Oman's main interests and concerns under GATS, in terms of specific sectors and modes, are mainly in important financial, telecom and energy sectors. Foreign service companies wishing to establish commercial presence in Oman can bring only 20% of foreign personnel from abroad for each company.

Effective from 1 January 2001, companies with foreign equity of up to 70% were subject to the same rate of taxation as Omani companies. Effective from tax year 2003, tax rates have been made uniform for all companies incorporated in Oman and permanent establishments in Oman of companies incorporated in other GCC countries. The rate applicable is 12% on taxable profits in excess of RO 30,000. In other words, Omani companies and foreign companies incorporated in Oman are treated equally, without discrimination. This development is expected to encourage foreign investors to invest in Oman.

Efforts are on to negotiate terms of trade in services including trade in health services by the ministries of trade and commerce but are usually not well coordinated with the Ministry of Health (MoH). This will have a negative impact on the expected health gains of globalization. Oman has overcome this situation by establishing the Higher Committee for WTO Issues and the Ministry of Health (MoH) is represented by a permanent member.

State of the domestic health-care system

Health expenditure has increased from RO 14.7 million (2.9% of government expenditure) in 1975 to RO 172.0 million (5.4% of government expenditure) in 2003. The per capita expenditure is RO 73.4. High-quality, free public health services provide about 95% of the total health services through 54 hospitals and 173 health centres distributed in different regions of the country, which employ about 20,338 health workers. From 2 hospitals with 12 beds in 1970, the total number of hospitals was 57 in 2003 with 5210 beds. The number of doctors has increased from 13 in 1970 to 3726 in 2003. The total health manpower is 23,137 of which 80.3% is under the MoH and 7.5% are in governmental non-MoH institutions (Table 1). Non-Omani health service providers represent 39%, 48% and 95.4% in MoH, non-MoH and the private health sector, respectively.

Table 1: Health manpower indicators (not including AFMS)

Health manpower indicators	2003	2002	2001	2000	1995	1985	1975	1970
Total doctors	3726	3536	3397	3258	2477	958	147	13
Doctors (per 10,000 population)	15.9	13.9	13.7	13.6	11.8	6.9	1.8	0.2
Total nurses	8580	8242	8014	7829	6036	2288	450	n/a
Nurses (per 10,000 population)	36.7	32.5	32.3	32.6	28.9	16.6	5.6	n/a
Total dentists	395	335	298	262	143	53	6	0
Dentists (per 10,000 population)	1.7	1.3	1.2	1.1	0.7	0.4	0.1	0
Total pharmacists	662	590	586	495	356	193	8	n/a
Pharmacists (per 10,000 population)	2.8	2.3	2.4	2.1	1.7	1.4	0.1	n/a

Source: Ministry of National Economy-<http://www.moneoman.gov.om>

Oman has a declared policy of 'Omanization' which enjoys support from highest levels of authority in the country. Under this policy, local production in the allied health sciences has expanded in the MoH, and more than 15 institutes have been established for this purpose. The result is reflected in the improved ratio of Omanis, which has gone up to 61% despite the overall expansion in health services.

The Sultanate of Oman is administratively divided into five regions and three governorates with 59 *wilayats*. The MoH provides free health services through its health institutions for all Omani nationals, GCC nationals and all public sector expatriates. There is a small annual registration charge (US\$ 2.85) and a nominal OPD visit fee (US\$ 0.52), introduced in late 1990 with a view to rationalizing

Table 2: Health programmes and services, 2003

Indicator	2003
Population size	2,341,000
Population growth rate	1.8
Life expectancy at birth	74 years
Infant mortality rate (per 1000 live births)	n/a
Maternal mortality rate (per 100,000 live births)	n/a
Children below 5 years with protein–energy malnutrition (rate per 1000 children below 5 years)	17.0
Diarrhoeal diseases (per child below 5 years per year)	0.3
Immunization in children one year of age (coverage %)	
BCG	98.1%
OPV3	99.9%
DPT3	98.8%
Measles	97.9%
Hepatitis B (HBV)	99.9%

the use of the hospital facility. The latest scientific approaches have been considered by the MoH in planning, monitoring and evaluating its health programmes and services (Table 2).

The public sector in Oman (MoH, Armed Forces Medical Services [AFMS], Royal Oman Police, Sultan Qaboos University Hospital and Petroleum Development Oman [semi-governmental]) is well funded, well equipped and efficient. It is estimated that 95% of the total population has access to the public health system. Mobile medical teams of the MoH run outreach clinics (by road, sea and air) in remote areas, providing for the remaining 5%. In fact, Oman has achieved the distinction of being rated number one by WHO for improved performance in health system efficiency and utilization of financial resources.

In implementing its health development plans, the organization of the MoH had to be adapted to fit in with the strategies and objectives that were crystallized during 1990. These can be summarized as:

- (1) Regionalization of health services and decentralization of decision-making in specified technical, administrative and financial affairs
- (2) Emphasis on the role and importance of planning
- (3) Development of education and training in health
- (4) Emphasis on the importance of health systems research
- (5) Emphasis on the importance of regional and international relations.

In addition to the MoH, other governmental organizations also provide health care for their employees and dependents. These include the Ministry of Defence, the Royal Oman Police and the Petroleum Development of Oman.

The private sector is small as compared to the public sector and caters mainly to expatriates employed outside the government sector. It had approximately 2778 employees in 2003, which represents about 12% of the total health manpower, three private hospitals (108 beds) and 631 private clinics. While specialized health-care-providing centres are located mainly in the capital, general practitioners run clinics in urban as well as rural areas. The government encourages setting up of private health-care facilities, which could, in the long term, reduce patient load in MoH establishments. There are currently 324 private pharmacies in the country, each with a registered pharmacist on the premises. Supply and distribution to the private sector appears to be compliant with government regulations. A price control system was introduced in 2002 and, as a result, prices of essential drugs in the private sector have fallen considerably. Prices are also consistent across the Sultanate. All private hospitals, clinics, polyclinics, pharmacies and laboratories are subjected to the licensing process of the MoH.

Oman finances its health system largely through the government budget. Table 3 indicates the World Bank estimates and government statistics in 1999.

Table 3: Government statistics, 1999

	RO million
Net public budget for health	156.6
Registration fees collected	1.4
Workman's compensation	3.1
Road accidents	0.5
Net government subsidy for health	151.5
Net private revenues for health	36.4
Net sponsor/employer payments	17.8
Out-of-pocket expenditure	18.6
Total revenues to finance the health sector	193.0

The public sector provides preventive, curative, promotive and rehabilitative services through high-quality hospitals and health centres that cover the Sultanate. Health institutions run by the MoH include regional hospitals that provide secondary and tertiary services to people of the region in which it is located, *wilayat* hospitals that provide primary and secondary health care, and small local hospitals that provide primary health care services to nearby villages. There are also three types of health centres. Some provide only outpatient primary health care, others provide primary health care and are also equipped with beds, and finally there are extended health centres that provide primary health-care and have some specialized clinics. The number of health centres is directly proportional to the size of the population in the region. Health services indicators have improved throughout the past 30 years (Table 4).

With the expansion of health services provided by the MoH, there has been a growing trend in utilization of such services over the years. Average daily outpatient visits have increased from 13,012 in 1980 to 28,431 in 2003. Omanis accounted for 96.54% of outpatients during 2003, the mean number of visits for Omanis being 5.6 compared to 0.6 for non-Omanis.

The MoH embarked on five-year health development plans in 1976. Following an analysis of the health situation, achievement of previous health plans, and problems and difficulties, the general

Table 4: Institutional capacity (health)

Health services indicators	2003	2002	2001	2000	1995	1985	1975	1970
Number of hospitals	57	56	56	55	53	44	24	2
Number of hospital beds	5210	5168	5200	5190	4564	3040	1000	12
Hospital beds (per 10,000 total population)	22.3	20.4	21.0	21.6	21.8	22.0	12.6	0.2
Bed/doctor ratio	1.4	1.5	1.5	1.6	1.7	3.1	6.8	0.9
Bed/Nurse ratio	0.6	0.6	0.6	0.7	0.7	1.4	2.2	n/a
Number of health centres, clinics and dispensaries (governmental)	173	172	166	161	163	130	51	22
Number of private clinics	675	631	641	560	471	255	n/a	n/a

policy of the MoH for 2001–05 was formulated. A control programme for AIDS was established in 1987 and continued as one of the programmes in the fifth five-year health development plan (1996–2000). A malaria eradication programme was started in 1991 resulting in a remarkable drop in malaria cases by 1994. However, one year later malaria was imported from East Africa and the Indian subcontinent. This led to the distribution of prophylactic drugs free of charge for travellers and screening of arriving passengers. Private institutions were involved in early case detection to cover cases coming from the Indian subcontinent. In 2003, there were 740 confirmed malaria cases of which 732 were imported cases.

The Expanded Programme on Immunization (EPI) continues to strive for high immunization coverage and reduction of communicable diseases, especially among children. Immunization coverage at the national level was almost 99% during 2003.

The National TB Control Programme was initiated in Oman in 1981. In the beginning of 1996, Directly Observed Treatment, Short-course (DOTS) was implemented all over the country. This resulted in conversion and cure rates of more than 90% and a sharp decline in TB deaths. During 2003, there were 250 TB cases registered showing an incidence rate of sputum-positive TB of about 4.8/100,000 population compared to 300 cases registered in 1996 and 405 cases registered in 1991.

Trade in health services under the four modes of supply

Cross-border supply (Mode 1)

Electronic delivery of health services, tele-health, tele-diagnostic surveillance and consultation services are not practised yet in Oman but there are plans for the future utilization of tele-health. The ministries of commerce, national economy and health are involved in setting up regulations related to data protection and the system for e-payment with the aid of a foreign consultant company. Medical students and health workers are the first categories that will benefit from tele-education and training. There are no restrictions on products and services available on the internet for personal use. The infrastructure for information technology (IT), electricity and internet connectivity are very efficient. Internet subscribers increased from 16/1000 population in 2001 to 22 in 2003. Almost all cities and towns are connected to Omantel, the main internet service provider currently.

The MoH provides up to 80% of health-care services in the country. The Sultan of Oman's Armed Forces, Royal Oman Police, Petroleum Development Oman and Sultan Qaboos University

also have hospitals, health centres and clinics. All concerned health workers have access to computers and the internet. Recently, the MoH established a Directorate General for IT to train health workers, and to design required programmes for electronic prescribing of medicines, storing clinical dates of patients, etc. A considerable proportion of MoH institutions are computerized. There is no evidence that e-health is being practised in the private sector. However, specialized private clinics and private hospitals have computers and access to the internet.

Oman has no existing or proposed commitments in GATS Mode 1 in health services.

Consumption abroad (Mode 2)

The Sultanate has an official policy to sponsor Omani patients for treatment abroad after all possibilities for treatment in the country have been explored. A duly constituted national committee of the MoH examines every request for treatment abroad, and makes a decision based on objective considerations. The number of people sent for treatment abroad was only 22 per 100,000 population in 2002, down from about 59 per 100,000 population in 1977. The decline in numbers reflects the diminishing importance of treatment abroad following the development of health services in the country. Upgradation of cardiac services resulted in a considerable decrease in the number of cardiac patients sent for treatment abroad, from 259 patients (1990) to only 32 (2002). The total expenditure on treatment abroad by the MoH is given in Table 5. Patients are sent to the UK (London), India and Germany.

Table 5: Cost of treatment abroad

Year	Expenditure
2001	US\$ 2,563,171.50
2002	US\$ 2,563,171.50
2003	US\$ 2,563,171.50

Source: Directorate of Private Clinics, MoH

Omani patients also go abroad for special treatment at their own expense while others may be sponsored by government institutions other than the MoH. Information on this type of health-seeking behaviour or sponsorship is not readily available. Health consumers are referred to India, the UK, Jordan, Kuwait, the UAE and Germany.

Omani students are deputed by the government for undergraduate diplomas, graduate and postgraduate degree programmes in other countries. In addition, there are students pursuing education in the health professions at their own expense, while others are sponsored by nongovernmental organizations (NGOs) and private individuals. The total number of medical students seeking overseas education (as per the Ministry of Higher Education) for the year 2003/2004 was 1341 of whom 52.2% were sponsored mainly by government organizations, 47% were self-sponsored, and 0.8% were sponsored by a private Omani company. Countries where students go at their own expense include India, the UAE and Jordan. Those sponsored by government or private companies get health education in the UK, Australia, the USA, Canada, New Zealand, and Kuwait among GCC countries. Estimates of financial resources spent on health education cannot easily be obtained.

The inward movement of foreign patients into Oman for utilization of local health services is not relevant at present. Development of health tourism by the private sector may be explored in the future.

Foreign students receiving health education in Oman represent a very small percentage. These students are from families working in Oman.

Oman has no existing or proposed GATS commitments in any health-related sub-sectors under Mode 2.

Regarding government regulations for going abroad to avail of health services, there are no restrictions imposed on private citizens going abroad for treatment. However, patients going for

treatment abroad at government expense require approval from the Treatment Abroad Committee, which gives permission after all the possibilities of treating the patient locally have been explored.

There are no specific government regulations for foreign consumers of private local health services. However, governmental health facilities provide treatment free of charge only for nationals, non-national government employees and GCC citizens. Others have to pay the allocated fees.

There is also no restriction on going abroad for studies. Foreign students moving into the country for local education in private schools are subjected to the regulations imposed by the Ministry of Education.

Commercial presence (Mode 3)

Oman has committed to allow foreign suppliers to set up business in the form of joint venture companies with at least 30% share going to Omanis for most sectors. However, Omani medicine and pharmacy practice law states that the owner of a health institution must be Omani or a citizen of a GCC country. It is therefore difficult to identify any FDI as all private hospitals, clinics, pharmacies and others, whether owned by locals or by foreigners, are registered under the name of a local owner.

The only existing commitment under Mode 3 is in the hospital services (CPC 9311) where foreign investment is permissible for hospitals having more than 50 beds. Currently, there are no proposed GATS commitments. The health sector has been opened to FDI along the lines of other service sectors. Perceived gains include the establishment of more private hospitals and clinics to cater to the needs of special sections of the population, i.e. expatriates and more affluent Omanis. The consequential benefit would be better and more prompt service for other Omanis from the governmental health services because of reduced load. The Ministry of Commerce and Industry is responsible for regulating FDI to the health sector. Even though commercial presence is allowed in the form of joint venture companies only if the Omani share is not less than 30%, there is a trend to allow foreign investment of up to 100%. While company registration takes place under the Ministry of Commerce and Industry, licensing of premises and compliance with technical regulations as well as licensing of technical personnel is the responsibility of the MoH.

Generally, wage levels provided by the public sector are higher and working hours are fewer than in the private sector. However, the situation differs with senior consultants. The number of local employees in the private sector is much less compared with foreigners. Recently, the MoH and University Hospital gave permission to senior consultants and specialists to work in private hospitals and specialized polyclinics outside working hours. This has resulted in an increase of national consultants and specialists in the private sector.

Table 6: Health manpower by category in Oman (as on 31 December 2003)

Category	Ministry of Health	Non-MoH governmental	Private sector
Doctors	2635	280	811
Dentists	144	12	239
Pharmacists	118	25	519
Nurses	7319	699	562
Assistant Pharmacists	604	25	154
Physiotherapists	118	16	16
Teachers/Tutors	218	0	0

Generally, public health services provided by the MoH, other non-MoH health institutions and the University Hospital are of a very high standard, free of charge and accessible. It is, therefore, the preferred service by locals and there is little possibility of shortage of health personnel or inefficiency in access to the health system due to foreign commercial presence.

Movement of natural persons (Mode 4)

This is the most important mode where expatriates play a dominant role in health service delivery in the private sector and an important role in the public health sector. The number of employees in the MoH rose from 15,423 (end-1998) through 17,167 (end-2001), 17,889 (end-2002), 18,558 (end-2003) to 19,255 (end-2004). The proportion of non-Omanis in the workforce during the same period fell from 51.3% through 44%, 41%, 39% to 35%.

Oman continues to be a net importer of health professionals. The workforce has been expanding over the past 14 years. This expansion has kept the up demand for expatriate staff, despite increasing indigenous capacity for training and graduation of health personnel.

The private sector continues even today to be almost fully manned by non-Omani health professionals. Health manpower statistics as on 31 December 2003 show that the number of health service personnel in the private sector is 2838, forming 12.2% of the total health manpower in Oman.

Most non-Omani health service providers in the private sector are from India, Egypt, Pakistan and Iraq. Health service professionals in the public sector (mainly consultants and specialist doctors) are from the UK in addition to India, Egypt, Pakistan and Iraq; pharmacists are mainly from Egypt and Sudan, while nurses are largely from India and the Philippines.

Oman has no existing or proposed GATS commitments in Mode 4 in health services. However, the Sultanate of Oman has a strong policy of 'Omanization', resulting in the replacement of existing expatriate professionals with Omani manpower when the latter is available. This policy is well implemented in the public sector, but might not be applicable to the private sector due to the shortage of Omani health professionals (Table 7).

Table 7: Percentage of Omani key professionals in the government sector
(as on 31 December 2003)

Category	% of Omanis	
	MoH	Non-MOH
1 Doctors	24	48
1.1 Medical officers	27	–
1.2 Specialists/Consultants	17	–
2 Dentists	36	92
3 Pharmacists	35	76
4 Nurses	49	17
5 Assistant Pharmacists	66	44
All categories (incl. others)	61	52

The government does not impose any restriction on health professionals moving abroad for temporary jobs, e.g. to work during annual leave, if this does not have a negative impact on their

normal work. There is no specific permission required for working abroad. However, in order to qualify for the benefits of the work, e.g. end-of-work benefits or retirement for Omanis, an approval from the employer is of great value.

Within the country, no health professional working in the public sector is allowed to own premises such as hospitals, clinics, etc. or to work in any other health institution (private or public) without special permission from their original institution. In the private sector, the expatriate employee must be sponsored by an Omani sponsor and as per Omani labour law, he can work only in the place identified in his labour card, in the same profession as identified in the labour card. The validity of the labour card is for 2 years, similar to the validity period of the working visa. In the public sector, expatriate employees are sponsored by the government. There is no restriction on the movement of Omani health workers between the two sectors. However, expatriates have to get a no-objection certificate from their current employer before joining the new employer (private or public).

Professional credentials are ascertained by the MoH and Ministry of Higher Education. All professional health workers applying for jobs in the private sector or MoH must appear for written and oral examinations conducted by the MoH. Those applying for jobs in non-MoH governmental institutions undergo evaluation by the concerned institution. This evaluation system is applicable to all health professionals, regardless of the country of origin. Citizens of GCC countries are exempted from rules of labour laws.

Consumption of health service abroad (Oman)

Outward movement of Omani patients

Equity: The official sponsorship of patients by the government for treatment abroad when the required service is not available locally, and the unrestricted free movement of private citizens desiring to avail treatment abroad help to achieve equity in extending this facility to those who are unable to pay for it on their own.

Quality: The Health Attaché in key cities identifies health-care institutions of excellence and ensures the quality of care extended to patients.

Efficiency: Considering economies of scale, the facility of treatment abroad in certain cases is highly cost-effective. Although outward movement of Omani patients is a regular feature, its importance is diminishing as Omani health services are developing. There is no evidence of inward movement of foreign patients to Oman.

Cross-border movement of students

Equity: The official sponsorship of students takes into consideration the merits of the candidate and national priorities, and is mainly in fields where local facility is not available.

Quality: The MoH has contacts with reputed international universities. In addition, most national educational programmes enjoy recognition from overseas accreditation agencies which facilitate the sponsorship of Omani students abroad.

Efficiency: In many specialized fields, Oman needs only a small number of professionals and it is more cost-effective to depute students abroad for such specialties. Also, the official policy of the government is to promote students to a better grade and a higher or more responsible position on return, thus encouraging them to return to the country after completing their education.

Presence of natural persons

Equity: Oman has lagged behind somewhat in the medical profession compared with other categories. The Sultan Qaboos University's College of Medicine was established in 1986 and has increased its intake of students admitted to the medical degree programme to about 100 per year. A private medical college has also been established recently. Currently, the import of human medical resources is having a positive impact in improving the health status of the Omani people. It has enabled a countrywide health system infrastructure, and thus helps to provide health services to the people in an equitable way.

Quality: Oman procures human resources from different countries. This might have a negative impact as the quality of health care provided by health professionals from various countries may differ due to different levels of professional excellence and background, as well as cultural and linguistic barriers among professionals and patients.

Efficiency: The presence of well-qualified and experienced non-Omani professionals facilitates on-the-job transfer of expertise and professionalism from non-Omani staff to young Omani recruits.

Oman has been persistently implementing an active 'Omanization' drive with a view to achieving self-sufficiency in human resources in the near future. It is believed that by 2005, dependence on foreign manpower in MoH institutions will decline significantly (physicians by 69%, nurses by 38% and assistant pharmacists by 24%). Despite the fact that foreign health professionals currently make high quality health care available in Oman, the MoH has been experiencing some problems in recruiting physicians (general practitioners) and some other specialized professionals. This is attributed to some extent to the fact that salaries offered in neighbouring GCC countries are higher than those offered by the MoH in Oman.

Conclusions and recommendations

In Oman, trade in health services has been taking place in at least two of the four modes of supply: Mode 2 and mode 4.

Consumption abroad (Mode 2): The outward movement of Omani patients for treatment is a regular feature. Its importance is diminishing as Omani health services are developing. There is no evidence of inflow of foreign patients to the country at present. The outflow of students for overseas education is cost-effective; however, financial resources have to be augmented.

Presence of natural persons (Mode 4): The inward movement of expatriate health professionals is beneficial to the health sector.

Cross-border supply (Mode 1) is not practised as yet and there is little evidence of foreign commercial presence (Mode 3).

In this context, the following steps are recommended:

- (1) Identification of additional financial resources that would help to reduce the burden on the MoH (cost-sharing)
- (2) Improvement in salaries of MoH staff to maintain the high quality of health care.
- (3) Maintenance of data by the MoH for all patients sent abroad for treatment (sponsored and nonsponsored).
- (4) Identification of the volume of FDI. Information should be maintained by the MoH about the true owners of private health institutions.
- (5) Incentives should be given to attract FDI and manpower in remote areas.
- (6) Research should be carried out on the value and volume of current and expected modes of trade in health services.