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The GATS Negotiations: Implications for Health and Social Services

Health and social services have so far attracted fewer commitments than virtually all other large sectors covered by the GATS. What are the reasons behind the low level of negotiating interest? What impact would GATS-bound reforms have on the provision of health and social services?

When Ministers initialled, in 1993, the Marrakesh Agreement Establishing the World Trade Organisation few could have imagined the public attention the new organisation would later attract. Almost every day it is being referred to either in newspapers, parliaments or street rallies – and not necessarily in a positive way. For trade policy veterans, this has certainly come as a surprise.

The General Agreement on Tariffs and Trade (GATT), the WTO's predecessor for almost five decades, had attracted far less press coverage and public scrutiny. It might have been well-known to small groups of business people, trade lawyers and researchers, but certainly not to a broad public. Since the GATT has essentially remained intact and continues to exist within the framework of the Marrakesh Agreement, what has caused the change in public attention (and apprehension)? Is the WTO fundamentally different?

There are indeed some differences. The WTO now rests on three main pillars. Apart from various agreements on trade in goods, centred mainly on the GATT, there are the General Agreement on Trade in Services (GATS) and the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). According to Article II:1 of the Marrakesh Agreement, the World Trade Organisation provides "the common institutional framework for the conduct of trade relations among its Members in matters related to … [these] agreements and associated legal instruments". Moreover, the new organisation is equipped with a binding dispute settlement mechanism, which no longer allows a defendant Member to use its own vote to prevent a ruling from being adopted. In turn, this reflects a certain shift in emphasis from policy-based consultation to rules-based litigation in addressing trade conflicts between Members. Diplomats seem to have ceded ground to lawyers. However, all agreements have retained a core function of the GATT: they define rules and principles for Members' conduct of trade-related policies in the areas covered.

There is little doubt, nevertheless, that there has been a climate change. At times, the "old" GATT might have attracted the wrath of relatively well-defined sector associations, in agriculture, coal mining or textiles, but it would not have caused mass demonstrations in the streets of Geneva and around the world. However, is services trade genuinely different from merchandise trade? Are protective regimes better suited in principle to the pursuit of social or infrastructural objectives that underlie the provision of many services? It is difficult to see why. If it is reasonable and beneficial for the economies involved to trade farm and food products, i.e. bare necessities of life, or basic infrastructural equipment, from trucks to trains and cranes, it might be equally reasonable to improve access to core service sectors. If such sensitive goods as pharmaceuticals can and, possibly, should be traded, the same rationale might apply to medical services as well.

Why the fuss about WTO and GATS?

- For some critics, WTO and GATS have become symbols of something they deeply resent: private ownership, market mechanisms, globalisation, loss of cultural identity, and the like. The fact that only few countries in the world are not Members and are not currently seeking accession, may provide only limited consolation in this context. Absence of a reference or rallying point might simply add to a sense of frustration.
- Professionals in some sectors, including doctors and teachers, may have suffered a culture shock when they learned of the (potential) extension of trade rules to their activities. The mere thought of being covered by a commercial agreement might have been difficult to digest. Misrepresentations about the implications of GATS, circulated in various

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professional journals, have certainly not helped to ease concerns.

- Finally, there is opposition of a more traditional, economic nature. Like farmers, miners or textile workers, professionals in protected service sectors may resent sharing their turf with foreign suppliers. Resistance to competition may be even fiercer in services, where protective barriers are higher in general than in manufacturing,[1] which has experienced nine rounds of trade negotiations since 1947/48.

The criticism levelled against the WTO and, especially, the GATS has not eased over time, quite the contrary. As the current round of services negotiations advances, within the overall framework of the Doha Development Agenda, many governments are under pressure to explain and, possibly, constrain their negotiating positions. While the guidelines for the services negotiations, approved by the Council for Trade in Services in March 2001, provide that there be no *a priori* exclusions from the negotiations, various Members have ruled out for themselves the possibility of making (additional) contributions in specified areas. These include not least socially or culturally sensitive sectors, such as health and other social services. For example, Commissioner Lamy recently stated, in a letter to the European Trade Union Confederation, that "Europe will make no offer nor give any undertaking in the field of education and health beyond the limited undertakings already given in the Uruguay Round" (4 February 2003).

The following parts revolve around two issues: the role of trade in the supply of basic public services, and the possibilities under the GATS to accommodate non-trade concerns. Can commitments under the Agreement be made compatible with, or even conducive to, core social policy objectives? A fourth part discusses emerging sectoral patterns of services liberalisation under the Agreement, while a fifth, concluding part focuses on the (potential) impact of GATS-bound reforms on the provision of health and social services.

International Services Trade: the Basic Rationale

International trade is driven by differences in prices, factor endowments (capital, technology, skills and manpower), and consumer preferences. Preventing or restricting trade in a non-distorted environment would be tantamount to squandering social and economic welfare. All participating societies/economies would ultimately be better off than in the absence of trade. This is subject to an important caveat, however: the existence of proper regulation and enforcement that would prevent, for example, negative spillovers on other persons and groups, and protect the weak.

Economic theory calls for public regulation and control in at least four circumstances, which are defined by the existence of:

- information asymmetries between market participants, e.g. suppliers and users
- economic or social externalities that are not reflected in market signals
- economies of scale, possibly leading to market dominance of one or more supplier(s)
- overriding policy objectives, such as social or regional equity and supply security.

Of course, there is value judgement implied. As a starting-point, markets are considered the preferable mechanism to coordinate supply and consumption of whatever product. The reliance on markets, in turn, rests on a three-pronged premise. First, it is the individual person, and his (her) preferences, that should ultimately govern resource use in a free society; second, he (she) is better equipped to express and act on these preferences, subject to the correction of eventual distortions, than collective decision-making; and, third, socially unacceptable income inequalities can and will be addressed through general tax and transfer policies that do not interfere with the coordinating role of markets.

In order for regulations to achieve their perceived objectives, certain conditions need to be met. In particular, the adverse social impact of an unregulated market should be higher than the risks associated with "regulatory failure" on the part of the governments and administrations involved. The latter cannot simply be assumed to be impartial advocates of the public interest, however defined, and to have more accurate information and foresight than private individuals or groups. The regulatory process itself is information and resource-intensive, and it is subject to vested interests lobbying for influence. It is thus conceivable, for example, that low-income economies are "under-regulated", lacking the means to generate and process necessary information and to operate independent supervisory agencies, while high-income economies may be "over-regulated", with regulations unnecessarily intruding upon essentially private affairs. Moreover, regulatory systems may be influenced by producer groups that have the means, contacts and incentives to collude, including established suppliers of mature products that may already benefit from government

[1] See, for example, The World Bank: Global Economic Prospects, Washington D.C. 2001.

intervention. Inventors and innovators, consumers and taxpayers typically play second fiddle.

Government monopoly provision is not necessarily a convincing alternative. Are there reasons to assume that public monopolies are more benign and responsive, in terms of social efficiency and user satisfaction, than regulated markets? Is public sector staff more immune to lobbying and selfish interest than other population groups? Are recruitment and promotion decisions in public administrations more objective and impartial than in private corporations? Not everybody may want to answer these questions with an unqualified "yes".

Nevertheless, few would deny the need for public involvement – at least through regulation, supervision and control – in the provision of health and social services. The existence of wide information gaps between supplier (doctor) and consumer (patient) is obvious and calls for appropriate regulatory control and legal protection. And anyone who is convinced of the virtues of an open, participatory society will possibly endorse the concept of universal access of all citizens, regardless of income and location, to a minimum set of goods and services, including pharmaceuticals and medical treatment. In Arthur Okun's words "Society refuses to turn itself into a giant vending machine that delivers everything in return for the proper number of coins."[2]

While there is a case for public monitoring and control of basic service sectors, it is difficult to see an equally strong case for protected markets and/or monopoly provision. The existence of market distortions – and the violation, for example, of basic equity, quality and/or safety objectives – does not necessarily imply a need for protective (or protectionist) entry barriers. Ideologists from both ends of the political spectrum might consider nationals to be more trustworthy by nature than foreigners and, possibly, their protected incomes to be premiums for altruism (a contradiction in terms). However, this does not appear to be a sound and generally applicable basis for policy action. The risk is real; throughout history, market restrictions have been used more often "to preserve unequal power and distinction for the few than to guarantee equal rights for the many".[3]

Available evidence in important service sectors, such as transport and communication, suggests that basic quality and equity objectives can be pursued via properly regulated markets.[4] Take the example of telecommunications, one of the traditional domains of government monopoly ownership, which has been fully liberalised in virtually all OECD countries over one or two decades. While moving closer to the effective cost of supply, prices for a wide range of services have tumbled, and it may be difficult to find users who pay higher phone charges today than before. (Admittedly, lower prices are not only attributable to stiffening competition, but to its interaction with rapid innovation.) Policy mechanisms have been developed within the EC and elsewhere to ensure better access conditions for disadvantaged groups or regions; such mechanisms may include universal service funds, direct subsidisation, or mandatory supply obligations. These mechanisms appear perfectly compatible with the open access regimes in telecommunications that the EC and others have bound under the GATS.

In sum, it is difficult to see why the same rationale – efficiency and growth – that has given rise to nine trade liberalising rounds under the GATT to date, should not apply to services as well. As already indicated, the growth and developmental effects would possibly be larger in services, given generally higher levels of protection than in manufacturing. Moreover, while access to goods markets may be subject to tariffs, services protection normally relies on entry or production quotas and other non-tariff measures, including discriminatory treatment in the context of licensing procedures, etc. Their use is less transparent and allows more scope for administrative discretion than price-based measures, and does not normally result in fiscal revenue. Quota allocation through auction is the exception, rather than the rule. Thus, it is easier for services barriers to escape public scrutiny and, at the same time, cause higher economic cost than equivalent customs tariffs, which at least generate public receipts.

Main Elements of the GATS

Although the underlying intentions are similar, there are conspicuous differences in structure and content between the GATS and the GATT. The scope of potential GATS disciplines is broader in at least two respects.

- The definition of services trade under the Agreement does not refer only to *cross-border* supplies, the traditional trade policy domain, but extends to three additional types of transaction or "modes of supply".

[2] Arthur M. Okun: Equality and Efficiency – The Big Tradeoff: Washington D.C. 1975, The Brookings Institution.

[3] Ibid.

[4] Of course, there are counter-examples of failure-prone electricity and rail transport systems. They certainly point to the need for prudent and effective regulation and control, but can hardly be blamed on the "market model" *per se*.

From the perspective of an "importing" country A, the GATS covers:

- cross-border trade (e.g. the provision of tele-health services into A)
- consumption abroad (nationals from A seek hospital treatment abroad)
- commercial presence (foreign hospital operators invest in A)
- presence of natural persons (foreign doctors or nurses treat patients in A).

The commercial importance of individual modes may vary significantly between sectors; for example, not all services are tradeable cross-border.

- GATS disciplines apply to service *supplies*, e.g. medical interventions, as well as to *suppliers*, e.g. hospitals, doctors and nurses. This signifies a major departure from the traditional GATT approach where access conditions are essentially determined by the physical characteristics of the product (good) concerned, rather than the production processes or producers involved. The broader scope of GATS takes into account that services regulations do not normally focus on the end-product only (bypass surgery, legal defence, architectural design etc.) but, rather, extend to the qualification and performance of the producer (surgeon, lawyer, architect).

The GATS' broader modal coverage reflects the need, in many services transactions, for the supplier and consumer to be in direct physical contact. Such contact can be achieved through either the consumer moving into the supplier's jurisdiction (mode 2) or the supplier being present – through commercial incorporation (mode 3) or personal movement (mode 4) – in the consumer's jurisdiction. Further, since services are often tailored to particular circumstances and the needs of individual customers, it may prove difficult to devise meaningful product standards. Typically, regulators pay more attention to ensuring competence and reliability of the persons and facilities involved, and the quality of the processes employed, than to specifying the actual outcome.

The broad coverage of the Agreement and its inclusion of process and producer-related regulation has not only complicated the structure of the Agreement, but affected its political acceptability. Sceptical observers tend to view it as a threat to national sovereignty. In fact, at a cursory glance, the GATS seems to be more politically intrusive – possibly extending to investment rules, licensing requirements and procedures, and the like – than its counterpart in merchandise trade. (This may have been an additional source of "fuss about GATS".) The Agreement is not just about "trade", i.e. the treatment of imports at national borders, but also covers policy measures, at whatever federal level, that may affect consumer movements, factor mobility and, in more general terms, the ability of governments to intervene in markets.

This is not the full story, however. The widening in scope of the Agreement is counterbalanced by a variety of flexibility provisions and some deliberate departures from sacred GATT principles. They are designed to accommodate sector and country-specific conditions, objectives and concerns.

- The GATS exempts services that are provided "in the exercise of governmental authority". The relevant definition covers all services that are supplied neither on a commercial basis nor in competition with one or more other suppliers (Article I:3(c)). In these areas, none of the Agreement's provisions apply, including those calling for further trade negotiations with the objective of progressive liberalisation. While the definition of such "governmental services" may offer scope for interpretation, the ensuing implications in practice, if any, are likely to remain limited.[5]
- Services that fall under the Agreement are not automatically open to foreign participation. WTO Members retain the right, at any time and without compensation of trading partners, to limit access to one or more domestic suppliers or otherwise to constrain trading opportunities. The only binding obligation in this context is the most-favoured-nation (MFN) principle, i.e. the requirement not to discriminate in the application of measures between like foreign services and service suppliers of different origin.[6]
- Access commitments apply only to sectors that are explicitly listed in Member-specific schedules of commitments ("positive listing"), and only to the extent that no qualifications ("limitations") or mode-specific exclusions have been inscribed. The range of schedulable restrictions – including access quo-

[5] In sensitive areas, Members may simply refrain from undertaking access commitments or expressly exclude socially relevant facilities from the scope of such commitments (see below).

[6] Even the MFN principle is not universally binding, but may be waived under certain conditions. These include membership in economic integration agreements (Article V); participation in mutual recognition agreements on standards, licences etc. (Article VII); and the occurrence of exceptional circumstances such as threats to life and health or public security (Articles XIV and XIVbis). Moreover, Members had the possibility, at the date of entry into force of the Agreement, to list MFN exemptions for periods not exceeding ten years in principle (Annex on Article II Exemptions). For a more detailed discussion see Aaditya Mattoo: MFN and the GATS, in: Thomas Cottier, Petros Mavroidis (eds.): Regulatory Barriers and the Principle of Non-Discrimination in World Trade Law, Ann Arbor 2000, The University of Michigan Press.

Table 1
Distribution of Services Commitments across Groups of WTO Members, May 2003

Countries	Average number of commitments	Range (Lowest/highest number of commitments per Member)
Least developed economies	18	1 – 104
Developing economies (excluding transition economies)	38	1 – 132
Developed economies[1]	103	80 – 110
Accessions since 1995 (mainly transition economies)	100	32 – 135

[1] Western Europe, Canada, United States, Australia, New Zealand and Japan.
Total number of sectors: ca. 160.

tas or prohibitions, foreign equity limitations, joint venture requirements, denial of national treatment with regard to taxes, subsidies or land ownership etc. – is far wider than would be permissible under the GATT. Moreover, commitments may be phased-in over years, at specified implementation dates, if governments want to avoid the risk of sudden disruption and/or need time to create the necessary regulatory infrastructure.

- Given the flexibility of the Agreement, it is impossible to find any identical schedules among the 140-odd WTO Members. The average number of sectors scheduled varies between less than 20 for least developed countries and over 100 for developed countries, with wide deviations in individual cases reflecting differences in economic philosophy, negotiating interest etc. (Table 1). The Agreement explicitly provides that "the process of liberalisation shall take place with due respect for national policy objectives and the level of development of individual Members, both overall and in individual sectors" (Article XIX:2). [7]
- The scheduling of limitations allows Members to condition private foreign participation in a sector as they see fit. Foreign equity ceilings, technology transfer and training requirements may be used, for example, with a view to increasing the social or developmental impact of foreign investment. Thus, of the market-access commitments WTO Members have scheduled under commercial presence (mode 3), over 80 per cent are subject to some type of limitation.[8]
- Commitments specify minimum levels of treatment; a Member is free at any time to offer more generous conditions than those laid down in its schedule. Also, pursuant to Article XXI, commitments may be downgraded, against compensation of affected trading partners, should they prove too burdensome for whatever reasons.
- The GATS does not undermine governments' ability in principle to regulate services and service suppliers for quality and other domestic policy purposes. Its Preamble expressly recognises "the right to regulate, and to introduce new regulation, … in order to meet national policy objectives". Governments are essentially free, even in fully liberalised sectors, to operate universal service obligations on private telecom providers, universities, hospitals, etc. if these are applied on a national treatment basis.[9] (Discriminatory obligations would need to be covered by a limitation.) By the same token, Members are entitled at any time to withdraw licences from suppliers not respecting relevant licensing conditions or domestic standards.
- The GATS not only contains similar exception clauses to the GATT, which provide cover for measures necessary to protect life and health, national security etc., but some additional provisions reflecting, *inter alia*, its wider modal coverage. For example, regardless of commitments on the presence of natural persons (mode 4), Members continue to be entitled to operate visa requirements and curb general migration flows (Annex on Movement of Natural Persons).

Despite its otherwise broad coverage, the GATS does not extend to one particular policy area: export-related measures. Contrasting with relevant GATT provisions, nothing in the GATS would constrain a government's use of export quotas, restrictions or incentives under any of the four modes of supply. Members thus remain free, regardless of the existence of commitments, to regulate the inflow of foreign patients, for example with a view to reserving hospital capacity for residents, or to subject their treatment to particular taxes or fees. (Resulting revenue might be used, *inter alia*, to fund capacity extensions or qual-

[7] Mauritius, on behalf of the African Group, went as far as stating that "[t]he Agreement: (i) recognizes the priority of development objectives; (ii) recognizes the primacy of national policy objectives, laws and regulations; and (iii) goes further than 'special and differential treatment' contained in GATT Part XIV in that it strengthens the relationship between commitments undertaken and advances in levels of development" (WTO document S/CSS/W/7, dated 4 October 2000). While this assessment may need to be read in the context of a particular negotiating situation at the time, its basic thrust seems to reflect the views of many developing countries.

[8] World Trade Organization: Market Access: Unfinished Business, Special Studies No. 6, Geneva 2001.

[9] Members' scope for introducing domestic regulations under the GATS, and the status of such regulations within the structure of the Agreement is discussed by Kalypso Nicolaïdis, Joel P. Trachtman: From Policed Regulation to Managed Recognition in GATS, in: Pierre Sauvé, Robert M. Stern (eds.): GATS 2000 – New Directions in Services Trade Liberalization, Washington D.C. 2000, The Brookings Institution.

ity improvements.) Likewise, there are no constraints on governments curbing the outflow of medical professionals, who might be attracted by more lucrative working conditions abroad, through mandatory service requirements in domestic facilities and other measures. Such "export restrictions", under either modes 2 or 4, might help to counteract adverse effects associated with increased mobility of consumers (patients) and/or staff.

Commitments on mode 2, consumption abroad, relate exclusively to the ability of *residents of the scheduling country to travel abroad* and consume a service (education, health etc.) without being impaired by constraints, for example, on the portability of scholarships or insurance cover etc. Such constraints would need to be covered by a limitation.[10] Unlimited mode 4 commitments would permit *foreigners to enter the scheduling country* on a temporary basis to supply a service without being subject to restrictions other than those resulting from general employment or visa policies.

It has been insinuated that the admission of a private supplier in addition to the (previous) government monopoly could lead to the relevant sector being automatically made accessible to any other interested company. This is obviously wrong, regardless of the application of the "governmental service carve-out" under Article I:3(c). The MFN rule does not, of course, oblige Members to relinquish a basic entitlement under the GATS – the imposition of quantitative restrictions on the number of suppliers, whether domestic or foreign – as long as the selection among foreigners is not governed by their respective nationality. Monopolies or duopolies are not GATS-inconsistent *per se*. Many countries around the world have gradually opened their telecommunication sectors to one or two additional operators in recent years – with the selection of companies being determined by auction, "beauty contests" and comparable mechanisms – and nobody has ever sought to challenge this under the GATS. In some cases, telecom monopolies have even remained in the hands of foreign private operators.

Others have warned against the allegedly rigid nature of commitments that may preclude future policy changes. It has been claimed, for example, that the existence of commitments on (commercial) health insurance might prevent governments from widening the coverage of existing (public) insurance schemes. Such concerns appear grossly exaggerated, to say the least. As noted above, Article XXI of the GATS explicitly permits, and provides a framework for, the modification of commitments against compensation of affected trading partners. Its non-invocation to date might suggest that the relevant provisions are more difficult to apply than their counterparts governing tariff modifications for goods (Article XXVIII of the GATT), which have been used in close to 300 cases since 1948. However, and possibly more likely, Members may also have felt less pressure to act, given both the flexibility of the GATS, which already allows obligations to be adjusted to conceivable future developments, and/or the generally modest levels of current commitments. Of course, this is not to propose that services commitments should be taken lightly; as for their counterparts under the GATT, the very purpose is to enhance stability and predictability of access conditions.

Table 2
Health and Social Services:
Country Pattern of Commitments, May 2003

Sub-sector[1]	Members with commitments[2]	
	Total	Developing and transition economies
Medical and dental services	62	44
Services provided by nurses, midwives, physiotherapists	34	17
Hospital services	52	37
Other human health services (ambulances etc.)	22	20
Social services	31	14
Other health-related and social services	7	7

[1] For an explanation of the sector definitions see Rudolf Adlung, Antonia Carzaniga: Health services under the General Agreement on Trade in Services, in: Bulletin of the World Health Organization, Vol. 79, No. 4, 2001, pp. 352-364. [2] The scope of individual commitments varies as a result of mode-specific exemptions or limitations. EC member States are counted individually.

Whatever concerns are raised about perceived structural flaws of the Agreement, it should be possible – more than seven years after the Agreement's entry into force – to produce empirical evidence. Some 60 WTO Members have undertaken commitments on medical and dental services, and about 30 Members have committed on social services (Table 2). The majority of these commitments have applied since January 1995.

The EC Schedule of Commitments submitted at the end of the Uruguay Round guarantees private investors in hospital services unimpeded access to five member countries: Denmark, Germany, Greece, Ireland and the United Kingdom. These and other sectoral entries are, however, subject to a horizontal limitation with which the EC has reserved the right to provide "services considered as public utilities" through public monopolies or protected private op-

[10] Cases in point are Bulgaria, Latvia, Poland and the United States with regard to insurance portability. See Rudolf Adlung, Antonia Carzaniga: Health services under the General Agreement on Trade in Services, in: Bulletin of the World Health Organization, Vol. 79, No. 4, 2001, pp. 352-364.

erators. There is apparently no evidence to date that these commitments posed a threat to public service or basic quality objectives. In a similar vein, India's 1995 schedule provides for unlimited access to the hospital sector under modes 1 to 3, except for a foreign equity ceiling of 51 per cent. While available empirical research, although patchy, suggests that foreign direct investment has had rather limited effects on the Indian hospital sector, there are certain indications, however, that greater competition might lead to improvements in quality, availability and prices: "To that extent, GATS and commercial presence in the health sector does represent an opportunity that can be used to benefit the country as a whole."[11]

Rough Times Ahead …

The absence of adverse effects in the past is, of course, not a guarantee for the future. This is particularly true in situations where both the framework rules and Members' access commitments may be changed. Rule-making negotiations, inherited from the Uruguay Round, are still under way in areas potentially relevant for health and social services: disciplines on domestic regulation, subsidies and government procurement.[12] In addition, pursuant to Article XIX:1 of GATS the new round of services negotiations started in January 2000 and has since been integrated into the broader framework of the Doha Development Agenda. The relevant GATS provisions require Members, *inter alia*, to enter into successive rounds of negotiations "with a view to achieving a progressively higher level of liberalization".

However, there is no common blueprint for future services liberalisation. As noted before, Article XIX explicitly provides that liberalisation take place with due respect for national policy objectives and the level of development of individual Members. No government will have to assume, at the end of the round, access commitments it is not prepared to accept. The same is true in principle for the rule-making negotiations; it would not be possible, against the authorities' intention, to subject a Member to new rules in whatever area. The consensus principle applies.

The chances are slim, therefore, that the services negotiations will result in both more open and more harmonised trading conditions across Members *and* sectors. While many Members seem ready to participate actively in the negotiations, the outcome is likely to be further liberalisation in some sectors combined with continued high levels of protection in others. This would contrast significantly with what happened in manufacturing trade in past trade rounds where not only tariff averages tumbled, but tariff peaks came down in many sectors as well.

Services liberalisation is likely to focus on infrastructurally important areas – "producer services" such as transport, telecommunications, financial services, distribution and various business services – that provide inputs for a broad range of user industries. Since user access to efficient supplies is an important determinant of international competitiveness, liberalisation of these services may be driven as much, or even more, by countries' economic self-interest as by requests received from trading partners.[13] The user industries, and their future investment decisions, may carry similar weight in the domestic consultation process to any defensive interests articulated in the infrastructural sectors earmarked for liberalisation. Moreover, adjustments in these sectors typically occur within an expanding business environment where redundancies are absorbed quickly by new start-ups.

Negotiating conditions for "consumer services", including health, education, social and cultural services, are obviously not subject to similar considerations. In addition, individual country regimes in these sectors are far more diverse, reflecting cultural preferences, institutional conditions etc., than those governing producer services. The latter have traditionally been provided in many countries on a commercial basis and, increasingly over time, by competing suppliers.

Some observers have speculated about external negotiating pressures that may cause governments to liberalise individual service sectors against their initial intentions and/or the interests of domestic stakeholders. This is not a particularly convincing view, however. GATT history suggests that negotiating positions are determined predominantly by domestic policy considerations, by producer rather than consumer interests and, in particular, by declining (shrinking) rather than emerging (growing) industries. Look at the goods sectors in which developed countries' trade regimes have typically continued to display high levels of protection: agriculture, textiles and clothing. The ensuing costs to domestic consumers and to foreign trading partners, mostly developing countries, have not apparently dominated the policy equation.[14]

[11] Indrani Gupta, Bishwanath Goldar: Foreign investment in hospitals and its implications for the health sector in India, paper presented at the ASEAN Workshop on GATS Agreement and its Impact on Health, Jakarta, March 2002.

[12] The relevant mandates are laid down, respectively, in Articles VI:4, XIII:2, and XV:1 of the GATS.

[13] See, for example, James Hodge: Liberalization of Trade in Services in Developing Countries, in: Bernard Hoekman, Aaditya Mattoo, Philip English (eds.): Development, Trade and the WTO, Washington D.C. 2002, The World Bank, and other contributions in the same publication.

More specifically, there is no intention of changing the architecture of GATS, including the "bottom-up" approach to scheduling individual sectors and the four modes of supply. It is inconceivable that, as a result of the round, participants will be required to liberalise a minimum number or a prescribed range of sectors. Nor will the modal structure of the Agreement be modified; there are no plans, for example, to create separate chapters on investment or on temporary entry for business persons under the GATS as they exist, for example, in the North American Free Trade Agreement. The March 2001 Negotiating Guidelines for services expressly provide that the Agreement's existing structure and principles be respected.[15] In addition, at the insistence mainly of developing countries, the Negotiating Guidelines call for request-offer negotiations to be the main approach. This necessarily limits the role, if any, of alternative negotiating mechanisms, such as horizontal formulae or model approaches.[16]

The results of the negotiations are subject to parliamentary ratification in most WTO Member countries. In the case of the EC, no less than 16 parliaments – the European Parliament and 15 national legislatures – will be involved. Sceptics may question the legitimacy or objectivity of the process. Nevertheless, despite all risks of bias, it is difficult to see where national interests could be more competently defined, and their pursuit ensured, than in freely elected parliaments. Who would otherwise weigh and balance the multitude of objectives that may be involved: protective producer interests, economy-wide cost and efficiency considerations, quality-related concerns, social policy concerns related to equity, distributional justice etc.? And where, if not in the WTO, could potentially affected (small) countries defend their interests should (large) trading partners seek to solve domestic policy conflicts at the expense of third parties? Services will be traded whether WTO and GATS exist or not, and there is no prize for guessing who would call the tune.

… or Much Ado About Nothing?

From a trade negotiator's perspective, health and social services seem to be the least interesting of all service sectors. They have attracted fewer commitments in current schedules than virtually all other large sectors, and it looks like the new round will not bring about major changes. Health and social services are the only large sectors on which no Member has circulated specific negotiating proposals.[17] Even in educational services, which proved similarly unpopular in the Uruguay Round and which share some of the social sensitivities surrounding health, four proposals were made. In total, 100-odd sector proposals have been tabled by some 50 Members.

The low levels of negotiating interest may reflect various factors. Administrations may not see a significant potential for trade in these sectors; may resent binding their supply regimes, current or future, in an international agreement; consider the ensuing benefits to be too modest to justify the administrative and political costs involved; and/or be concerned about their ability to regulate and properly monitor developments in socially sensitive areas. The first consideration is possibly the least compelling, given that virtually all Members are involved in health service trade under at least one mode of supply, consumption abroad (mode 2), and many have become used to foreign professionals working in their hospitals (mode 4). Uncertainties about ongoing reforms and the need for future change may be a more relevant motive. Health officials in many countries, regardless of the organisation of their respective sectors, are confronted with a variety of crisis symptoms, including cost pressures, waiting lists, staff shortages, quality problems, risk of social exclusion etc. They may not want to tie their hands, in whatever context, and they may feel more confident about their traditional role as health service providers than as regulators of commercial hospitals.

The absence of significant commitments under the GATS would not only ensure full flexibility for future policy change, but also allow for the perpetuation of existing restrictions.[18] While this may appear attractive from the vantage point of health administrators and sector incumbents, it could also impact on the effectiveness of reform options that may be under consideration.

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[14] Available evidence for many developed countries suggests that the structure of tariff protection is regressive, i.e. that it puts a disproportionate burden on low income families. For example, it has been estimated that a US working welfare leaver who earns some US$15,000 a year loses about 1.9 per cent of his income, i.e. one week's salary per year, to import tariffs on products such as shoes and clothes. Families with an average income of US$110,000 lose only about 0.6 per cent (Edward Gresser, Toughest on the Poor – Tariffs, Taxes and the Single Mom, Progressive Policy Institute, Policy Report, September 2002). In turn, the bias of tariff protection against the poor is likely to affect social welfare and, possibly, public health.

[15] WTO document S/L/93, dated 29 March 2001.

[16] See Rudolf Adlung: Liberalizing Trade in Services: From Marrakesh to Seattle, in: INTERECONOMICS, Vol. 34, No. 4, 1999, pp. 211-222.

[17] Negotiating proposals have been submitted to the Council for Trade in Services since March 2001. They have been used to draw attention to trade problems encountered by the Member(s) concerned in individual sectors, relevant negotiating objectives and possible implementing strategies. Health and social services may, however, be covered implicitly by some horizontal proposals, in particular those concerning the presence of natural persons, as well as various proposals on professional services (medical and dental services are subcategories of professional services, while hospital and social services are a category in their own right). All proposals are available on the WTO website.

Take the case of a developing country that, due to capacity or quality problems in its national health system, experiences significant outflows of patients for treatment abroad. Since mobility tends to be selective, well-to-do persons are normally over-represented, implying a loss of "purchasing power" that might otherwise be used to build up domestic supply alternatives. Young, well-educated staff may decide to follow in order to capitalise on their skills and expertise. This does not add up to a particularly attractive scenario, either from an economic or a public health perspective, keeping in mind that the foreign hospital operators could also invest in the home country of the patient. Such investment could be facilitated through internationally enforceable policy bindings and their positive impact, from a potential investor's point of view, on the predictability and reliability of commercial conditions.

This is the point where the GATS may come into play, depending on the individual Member's policy choice. Potential implications for public health may include: (i) a contribution to equity objectives as the investment could be made subject to universal service obligations benefiting the poor; (ii) a contribution to quality objectives through associated gains in skills and expertise and/or reduced levels of "brain drain"; and (iii) the possibility of stricter regulatory control as compared to a situation, under mode 2 (consumption abroad), where the service is provided in a foreign jurisdiction. Of course, such potential benefits need to be set against conceivable risks, including the possibility of internal migration of qualified staff from public to private facilities and any ensuing supply gaps for low-income groups.[19]

The binding effects associated with commitments on commercial presence (mode 3) may prove less dramatic than has been suggested in some publications. About 2000 bilateral investment protection agreements have been concluded by governments around the world with their main commercial partners. They typically protect against expropriation and provide for national treatment on a post-establishment basis (a few agreements even provide for unfettered national treatment). In the absence of particular sector carve-outs, this implies that, whenever a foreigner has invested in a sector, he is as well protected as any national investor. Moreover, pursuant to the MFN requirement, investors from all WTO Members need to be admitted on similar terms and conditions. The option of returning to square one, i.e. making foreigners leave the sector again, may thus prove rather cumbersome in such cases, even in the absence of commitments under the GATS.

This does not imply that, where such investment protection agreements exist, governments may have no negotiating interest in the ongoing round. The broad modal scope of the GATS offers an almost unique opportunity to discuss, and seek or offer commitments on, all relevant modes in a mutually consistent way. (A government that considers liberalisation of hospital services under mode 3 may want to request other Members, for example, to consider undertaking commitments under mode 2 that would ensure insurance portability for their patients travelling abroad.) Two more general policy considerations may also prove relevant. First, the negotiations may constitute a much needed incentive to ensure internal policy coordination between and within relevant Ministries and agencies, regardless of the final outcome. Second, they can, and should, be used to identify synergies between individual sectors and define coherent trade and development strategies. Such strategies could aim, for example, to capitalise on a country's natural attraction for travel and tourism.[20]

The absence of broadly circulated proposals suggests that such considerations have not determined negotiating positions to date. It would be misleading, nevertheless, to conclude with "Much Ado About Nothing". If the ultimate objective is to further public health and social welfare, the negotiations, on services and beyond, are highly relevant. Trade liberalisation, complemented by an appropriate legal and institutional framework, can be a powerful source of economic and social development.[21] It would thus be too narrow a perspective to associate the WTO's potential contribution to health and welfare with trade and investment conditions in a handful of health and social services. What ultimately matters is the general level of openness – and stable access to internationally available resources – across a broad range of economic activities, within a conducive macroeconomic environment.

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[18] As noted above, in services covered by the GATS, the only significant constraint on a Member would be the most-favoured-nation principle, i.e. the requirement not to discriminate between other WTO Members. However, there is no limit on the scope and restrictiveness of the measure actually applied, be it free entry or a complete ban on access.

[19] Susan Cleary, Stephen Thomas: Mapping Health Services Trade in South Africa, TIPS 2002 Annual Forum (www.tips.org.za/research/papers/showpaper.asp?ID=569). See also Indrani Gupta, Bishwanath Goldar, op. cit.

[20] Possible slogan: "Thailand offers sun, sand, and surgery" (Financial Times, 12 August 2002).

[21] David Dollar: Is globalization good for your health?, in: Bulletin of the World Health Organization, Vol. 79, No. 9, 2001; and Alan L. Winters: Trade Policies for Poverty Alleviation, in: Bernard Hoekman, Aaditya Mattoo, Philip English (eds.), op. cit.