Health services under the General Agreement on Trade Services[1]

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INTRODUCTION

The concept of international trade in services is relatively new. Unlike the bulk of agricultural and industrial production, services have long been considered not to be tradable across borders or, more generally, over distance. The only significant exceptions have been services directly related to the exchange of goods (transport, insurance, etc.) and, more recently, to tourism. The generally low level of trade in services has been attributed to institutional, administrative and/or technical constraints, such as the existence of public monopolies (education, telephone services), strict access regulations and controls (finance, various professional services) and the need for direct physical contact between suppliers and consumers (as in health and other social services). However, in an increasing number of sectors such constraints have diminished or have even disappeared. The advent of new communication technologies, including the Internet, has helped to reduce distance-related barriers to trade. Governments have begun to reconsider their role in the provision of services, and this has presented new opportunities for private participation, both domestic and foreign.

The entry into force of the General Agreement on Trade in Services (GATS) in 1995 confirmed the global trend towards the reorganization and restructuring of services. The Agreement was a milestone in the history of the multilateral trading system, comparable to its counterpart in merchandise trade, the General Agreement on Tariffs and Trade (GATT), which came into effect in 1948. GATS provides a system of predictable and legally enforceable conditions for services trade, and has a potentially positive impact on investment, efficiency and growth. Notwithstanding some public misperceptions, its hallmarks are pragmatism and

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flexibility. Given the traditional consensus principle of the World Trade Organization (WTO), this was the only conceivable approach to devising an Agreement involving some 140 participants, including about 70 developing and 30 least developed countries. All WTO Agreements have been signed and ratified by all Members, implying approval by their national parliaments in many cases.

Member countries have committed themselves to the progressive liberalization of services trade, in accordance with GATS Article XIX:1, regardless of the launching of any more comprehensive negotiations within the remit of WTO. A new services round was thus launched on 1 January 2000. It can be expected to promote further market liberalization or at least to translate into legally binding obligations what has already been achieved autonomously, and thus advance or consolidate developments that have been going on for years in many countries.

The commitment to future negotiations is without precedent in GATT. Past trade discussions were initiated by large Members, usually the USA, which felt that the time was ripe to advance liberalization, redefine rules and close perceived loopholes in the system (*1*). The launch of negotiations thus depended essentially on the existence of a leader with political vision and economic power. The fact that GATS has institutionalized this process may be attributed, at least in part, to the exigencies of a broader-based and increasingly diversified trading system. Its membership and its coverage in terms of sectors and measures have expanded over the past decades.

As the impact of liberalizing forces varies significantly among countries and sectors, so do the access commitments currently listed under GATS. While over 90% of WTO Members undertook some form of commitment on tourism services and about 70% included financial or telecommunication services in their Uruguay Round schedules, less than 40% made commitments on education and health.

Education and health services have traditionally been subject to strong government involvement in many countries and this situation has changed far less rapidly than the role of governments in, for example, banking or telecommunications. From the standpoint of individual health ministries and health-related associations, the Uruguay Round might have been viewed as a threat, jeopardizing basic quality and social objectives, rather than as an opportunity for reform that would improve efficiency. Initial reservations have been compounded by a variety of other factors: uncertainties stemming from the novelty of the Agreement, widespread inexperience in concepts of services trade, and, in many countries, the absence of well-established coordination between competent sectoral ministries and agencies on the one hand and the trade negotiators in charge of GATS on the other. However, problems of information and coordination also existed in other service areas, which nevertheless drew far more commitments than health or education. It may have been social and distributional concerns that led Members not to volunteer or negotiate commitments in these two areas.

However, many concerns surrounding GATS are unfounded. For example, the Agreement clearly distinguishes between external access liberalization and governments' rights

to regulate for quality purposes. It also offers an enormous degree of flexibility, allowing Members to continue pursuing basic policy objectives in liberalized sectors. Access commitments can even be made contingent on new entrants, such as hospitals and doctors, contributing directly to these objectives. The present article is intended to explain such possibilities. We provide an overview of the basic structure of GATS, patterns of current access commitments under the Agreement, and limitations frequently used to qualify such commitments in health services. Finally, we discuss possible approaches to combining trade policy with sectoral policy objectives and indicate issues that may need to be tackled in the current round.

Basic structure of GATS

GATS allows Member countries to assume legally-binding commitments concerning their use or renunciation of trade-related measures in individual service sectors. These commitments are laid down in country schedules, one for each Member. There is wide scope to adjust schedules to domestic policy objectives and constraints. For example, GATS does not prescribe the number, level or sectoral pattern of a country's commitments and does not compel Members, even in sectors they include in schedules, to offer conditions that are more liberal than the prevailing trading conditions. A large majority of schedules have been confined to confirming the status quo or to guaranteeing only some form of minimum trading rights below present levels. In some cases, moreover, it appears that commitments have only conceded what governments were unable to control in any event, as with the use of electronic media to interact with services suppliers established abroad, such as doctors, lawyers or architects.

The scope and content of a schedule may be taken as a first indication of a country's basic policy orientation. Confidence in market-driven adjustment would normally translate into many relatively liberal commitments, while preference for administrative guidance or dislike of foreign influence would lead to fewer and more restrictive entries. Nevertheless, schedules need to be interpreted with care. It could be misleading, for example, to infer directly from the absence of commitments that there is an absence of trading opportunities. There may be various reasons for individual Members not to schedule sectors in which they nevertheless maintain few barriers to trade. These can include unfamiliarity with the Agreement, lack of negotiating requests, and the desire to retain negotiating leverage for future trade rounds.

Schedules of service commitments are longer and more complex than tariff schedules in the area of goods. A simple tariff schedule may consist only of two columns juxtaposing on the same line a product classification number and the corresponding tariff rate. In contrast, trading conditions for any scheduled service sector are defined in at least three columns, covering product description and two types of commitment, and four lines. This arises because of the absence of tariffs in services, making it impossible to use a single indicator to determine market entry, and because GATS involves a more comprehensive definition of trade. Reflecting the need in many service sectors for direct physical interaction between supplier and consumer, the range of

transactions covered by GATS is particularly broad. The Agreement not only embraces the traditional concept of cross-border trade in the form of country A importing products from abroad (mode 1; see Box 1), but extends to A's residents consuming services in foreign markets (mode 2), foreign suppliers establishing a commercial presence in A (mode 3), and people (designated legally as "natural persons") moving into A for the purpose of providing a service (mode 4).

Recent estimates, based on limited empirical information, suggested that modes 1 and 3 each accounted for about two-fifths of the world trade in services, while mode 2 contributed one-fifth; mode 4 was found to be insignificant. It would not be surprising if the relevant shares for health services were of the same order, although mode 4 and, possibly, mode 2 may be more important than in most other sectors. In any event, given the existence of many technical, institutional and economic barriers, the role of trade is likely to be more limited in the health sector than the overall share of services trade in world production, which amounts to some 7–8% at present, as estimated on the basis of 1998 data on world gross domestic production and world commercial services exports and of a recent study by Karsenty (*2*).

For any sector included in its services schedule, a Member is held to specify the commitments that it is prepared to undertake on market access and national treatment. The meaning and the legal implications of these commitments are indicated in Articles XVI and XVII of GATS (Box 1). Since they each apply to the four modes of supply, trading conditions are ultimately defined in the form of eight entries per sector. These may vary within a spectrum whose opposing ends are guaranteed market access and/or national treatment without limitations (full commitments) and the denial of any such guarantees (no commitments). While the relevant entry would be "none" in the former case, the absence of commitments would be indicated as "unbound".

It would have been simpler, of course, to provide for only one level of commitment per sector, governing at the same time trading conditions across all four modes and, possibly, market access and national treatment. However, this would have meant that the most sensitive policy domain determines conditions for all conceivable forms of transaction. In contrast, the structure of the Agreement allows a country that finds it impossible to commit itself under mode 4 (presence of foreign natural persons, e.g. physicians and nurses) to extend market access and national treatment under mode 1 (e.g. cross-border imports of telehealth services), mode 2 (residents moving for medical treatment abroad) and/or mode 3 (foreign inward investment in hospitals).

The nonscheduling of a sector or a noncommitment on a particular mode do not imply that the relevant policies are beyond all GATS disciplines. Some basic obligations — first and foremost, the most-favored-nation (MFN) principle — apply regardless of such circumstances. Any form of discrimination between trading partners on grounds of nationality is prohibited. The only exemptions relate to mutual preferences between participants in economic integration agreements, such as the European Union or the North American Free Trade Agreement, and to recognition

Box 1. Scope and structure of commitments under GATS

Specific commitments on market access and national treatment

A WTO Member must specify, for each sector in its services schedule, two types of legal obligations concerning, respectively, market access and national treatment. The granting of market access implies that the Member must refrain from operating any of six types of restrictions enumerated in Article XVI of GATS. These are mostly quota-related barriers that may limit, for example, the number of service providers (hospitals, doctors, etc.) or operations (number of beds, practices, etc.). Also precluded under this Article is the use of economic needs tests, e.g. the conditioning of access approvals on pre-established indicators such as the number of hospital beds or practices per head of population. It is irrelevant in this context whether such measures are nondiscriminatory (i.e. include national suppliers) or not. Article XVII defines national treatment as the absence of any measures that modify the conditions of competition to the detriment of foreign services or service suppliers. Although the Article provides no further guidance, it is understood that a full commitment would prevent, for example, foreign-owned hospitals from being excluded from subsidies or other benefits under domestic policy schemes. Denials of market access and national treatment are not prohibited per se, but they must be listed in the schedule as limitations. Limitations applying to all scheduled sectors may be inscribed in a horizontal section to avoid repetition.

Commitments may vary across regions (states, provinces, etc.) within a scheduling country, and their entry into force may be postponed to a later date— i.e. pre-commitments are made.

The concept of services trade: four modes of supply

GATS significantly extends the traditional concept of cross-border trade by distinguishing four modes of supply. For any sector included in a schedule, Members are held to specify the market access and national treatment obligations with regard to each of these modes. Their definition is based on the territorial presence of supplier and consumer at the time a service is provided: both parties may reside in different territories (mode 1), the consumer may have moved abroad into the supplier's country (mode 2), the supplier may have established a branch, subsidiary, etc. in the consumer's territory (mode 3), or, in the case of natural persons, the supplier may be physically present (mode 4). A typical example for mode 1 trade, from the scheduling ("importing") country's perspective, is that of foreign medical specialists sending advice, e.g. via the Internet, to domestic doctors or hospitals. In contrast, under mode 2, residents travel abroad to obtain treatment in a foreign clinic or practice. Modes 3 and 4 would apply, respectively, to foreign investments in a country's hospital sector and the presence of foreign medical staff in these hospitals.

The borderline between modes is not always clear. For example, the definition of mode 2 under the Agreement does not explicitly require the consumer to move abroad physically, and the question has therefore arisen as to whether certain transactions carried out electronically would also fall under this mode.

Not all modes of supply are equally relevant in all sectors. For instance, while it is relatively easy to conceive of medical advice being provided via all four modes, the supply of nursing services does not seem to be possible under mode 1. Some Members have nevertheless inscribed a full commitment in such cases. Others have scheduled "unbound", adding in many instances that such supplies are not considered to be technically feasible. It could thus be misleading to associate the absence of commitments with restrictive policy intentions.

Rules governing domestic regulation, other provisions and exemptions

Members are free to pursue domestic policies in areas such as internal standards, licensing and qualifications to ensure the quality of a service. For example, private hospitals may be required to train more staff than needed for their own purposes, reserve a specified number of beds for needy patients, or operate emergency services in remote areas. To the extent that such requirements do not focus on, or otherwise discriminate against, foreign suppliers, they do not fall under Articles XVI and XVII and must not be scheduled.

Members are allowed to downgrade specific commitments through the modification of schedules. However, such modification must be negotiated, possibly against compensation, with affected trading partners. In addition, GATS makes provision for the temporary suspension of commitments in the event of balance of payments problems. A general exception clause exempts Members from any obligations where this is required by overriding reasons of policy (protection of life and health, etc.). These provisions have not been invoked to date.

GATS applies only to measures that (i) are taken by governments, at whatever level, or government-mandated bodies, and (ii) impinge on the supply of services through any of the four modes. It might thus prove impossible to prevent private operators from discriminating against foreign suppliers (e.g. health insurers vis-a-vis foreign hospitals) or to successfully challenge export-related measures (e.g. incentives to attract foreign patients) if these have no discriminatory effects in sectors and modes subject to specific commitments.

measures in the areas of licensing, certification and technical standards. Thus, while a WTO Member may prohibit all trade in a noncommitted sector or mode, it must, as a rule, operate this prohibition on an MFN basis, i.e. vis-a-vis all its trading partners. Exemptions from MFN treatment could have been sought, for a period not exceeding 10 years in principle, at the date of entry into force of the Agreement or, for new WTO Members, at the date of accession. Any later exemption would be subject to relatively onerous procedural constraints, and there have been no such cases to date.

The MFN obligation is a powerful guarantee, in particular for small and less economically developed Members, allowing them to participate automatically in any liberalization that Members with more negotiating leverage may be able to achieve. There is thus less risk of economically weaker countries being sidelined by deals struck between larger participants. A problem for these countries is their lack of influence on the sectoral pattern and modal focus of such deals. This problem may also arise in rounds of trade negotiations. Thus it has been argued that the export interests of large OECD industries, including banks, insurance companies and telecommunications operators, provided most of the negotiating momentum that helped to bring the Uruguay Round to a successful conclusion and to shape current commitments in services. This does not imply, however, that the negotiating process was biased against smaller and weaker participants. On the contrary, many developing countries saw and seized the opportunity in these negotiations to bind their trading conditions, in particular for mode 3, and thus to create more predictable and economically attractive conditions for foreign investment in infra-structurally important areas. Nevertheless, the question arises as to whether there are other sectors and modes, possibly including trade in health services under modes 2 and 4, where developing countries have active commercial interests and could not rely on large Members giving direction. The new round may be viewed as a challenge for these countries, i.e. the vast majority of the WTO membership, to define their interests more clearly and pursue them with vigor.

It has been argued that the existence of commitments under GATS could impinge on the ability of governments to regulate the services concerned. This reflects a profound misunderstanding. The Agreement makes a clear distinction between external liberalization, covered essentially by Articles XVI and XVII, and internal regulation for quality and similar purposes. However, the GATS rules on regulation, laid down in Article VI, are still rudimentary. The only exception is the accountancy sector, for which Members agreed on a set of regulatory disciplines in 1998. One of the core elements is a necessity test, which essentially requires that technical standards as well as licensing and qualification requirements and procedures be no more restrictive on trade than is necessary to fulfill a legitimate objective. Accordingly, under the accountancy disciplines it would be inadmissible for a Member that has scheduled commitments in this sector to make participation in a professional examination conditional on the applicant being resident or to charge fees not related to cost. However, there is nothing in these disciplines that would constrain the right of

governments to determine the legitimate quality objectives within their jurisdiction. The Agreement merely contains an illustrative list of such objectives, including the protection of consumers and the integrity of the profession. Work is under way with a view to extending such disciplines to other sectors. It is difficult to anticipate their precise content but it is clear that the ensuing disciplines would not affect the right of Members to regulate.

Moreover, a general exception clause in Article XIV allows Members to depart from any obligation under the Agreement if this is necessary to protect human, animal or plant life or health, subject to the proviso that there be no arbitrary or unjustified discrimination or disguised restriction on trade. The clause might provide legal cover, for example, for a prohibition on over-the-counter sales of potent pharmaceuticals or for travel bans in the event of epidemics. As a general rule, however, protection from substandard medical services and service providers does not depend on this exception but can be ensured under normal GATS provisions, i.e. Article VI.

However, there is one wholesale exemption. Pursuant to Article I:3, the Agreement does not apply to services provided in the exercise of governmental authority. The relevant definition of such services rests on two elements: they must be provided neither on a commercial basis nor in competition with one or more suppliers. Typical examples include fire protection or police services, and the monetary operations of central banks. Article I:3 may prove equally relevant in the health and education sectors; free treatment in a country's public hospitals or free education in public schools and universities are cases in point. Whatever a country's access barriers in such areas, they could not be challenged under GATS or draw requests for liberalization in future trade rounds. This implies that the privatization or commercialization of services previously falling under Article I:3 would automatically extend the application of the Agreement to these services. The MFN principle and some relatively soft administrative and institutional obligations, including a transparency requirement, would then apply. The mere coexistence of governmental and private services in the same sector would be of no relevance in this context. It would be absurd to believe, for example, that the availability of private medical or private security services in a country would require the government to commercialize its public hospitals or police.

Current patterns of access commitments

The number of sectors committed by individual WTO Members tends to be positively related to their level of economic development. Developed countries apparently found it easier, or more economically beneficial, than the majority of developing countries to submit relatively extensive schedules. The commitments of one-third of WTO Members, all developing and least developed countries, were confined to 20 or fewer of the approximately 160 services sectors defined during the Uruguay Round. Another one-third scheduled between 21 and 60 sectors, and the remaining third included up to about 130 sectors. However, the composition of the latter group is not uniform: it not only comprises virtually all OECD Members but also several

developing and transitional economies and even a few least developed countries (the Gambia, Lesotho, and Sierra Leone).

The country pattern of commitments in health services is even more diffuse. One member, Canada, has not undertaken commitments in any of the four relevant subsectors (medical and dental services; services provided by midwives, nurses, physiotherapists and paramedical personnel; hospital services; and other human health services such as ambulance services and residential health facility services), while Japan and the USA have scheduled only one (Table 1). This contrasts with least developed countries such as Burundi, the Gambia, Lesotho, Malawi, Sierra Leone, and Zambia, which have included at least three subsectors. Estonia, Georgia, Jordan, the Kyrgyz Republic, and Latvia, which recently joined WTO, also undertook relatively extensive commitments. Nevertheless, no service sect or other than that of education has drawn fewer bindings among WTO Members than the health sector (*3*).

Of the four subsectors, medical and dental services are the most heavily committed (54 Members), followed by hospital services (44 Members) and services provided by nurses, midwives, etc. (29 Members). Overall, this pattern suggests that it is politically easier or more economically attractive for administrations to liberalize capital-intensive and skills-intensive sectors than labor-intensive activities (Table 2).

What factors could explain the generally shallow level of commitments on health services? The most obvious reason is the existence of government monopolies, in law or in fact, offering services free or significantly below cost. There seems to be no point in assuming external policy bindings, at least under mode 3 (commercial presence), if private activities are either prohibited or rendered commercially unattractive. However, total monopoly situations are likely to be rare. In many countries with a public health sector there are also private suppliers. The mere fact that commercial providers are able to survive economically suggests that the public and the private segments do not compete directly, which means that they do not provide the same services. For example, there may be differences in waiting periods, quality of equipment, or types of treatment offered. With this in view, five WTO Members (Latvia, Malaysia, Mexico, Poland, and Slovenia) confined their commitments to various parts of the private health sector. Nevertheless, given prevailing policy patterns in many countries, the potential for mode 3 trade, and consequently for meaningful commitments, may have been lower in health services than in many other areas.

Requests for liberalization, or liberal policy bindings, in the Uruguay Round might also have been weak in this sector. In the absence of vocal export interests, many governments might have hesitated to request access commitments abroad and to reciprocate by way of their own bindings on health services. There were apparently no pace setters in these negotiations comparable to the role played, owing to strong export interests, by the USA, the European Union and other OECD countries in areas such as telecommunications and financial services. Moreover, as noted above, many administrations might have been concerned, rightly or wrongly, about the potential impact of access liberalization on basic social

Table 1. Specific commitments of WTO Members on individual health services, July 2000 (countries and areas listed according to WTO designations)

Members	Medical and dental services	Nurses, midwives, etc.	Hospital services	Other human health services	Members	Medical and dental services	Nurses, midwives, etc.	Hospital services	Other human health services
Antigua and Barbuda	X				Kyrgyz Republic	X	X	X	X
Australia	X			X	Latvia	X	X	X	
Austria	X	X	X	X	Lesotho[a]	X	X		X
Barbados	X				Malawi[a]	X	X	X	
Belize	X			X	Malaysia	X		X	X
Bolivia			X		Mexico	X	X	X	
Botswana	X	X			Norway	X	X		
Brunei Darussalam	X				Pakistan	X		X	
Bulgaria	X				Panama			X	
Burundi[a]	X		X	X	Poland	X	X	X	
Congo DR[a]	X				Qatar	X			
Costa Rica	X		X		Rwanda[a]	X			
Czech Republic	X				Saint Lucia			X	
Dominican Republic	X		X	X	Saint Vincent and the Grenadines			X	X
Ecuador			X		Senegal	X			
EU(12)	X	X	X		Sierra Leone[a]	X	X	X	
Estonia	X		X	X	Slovak Republic	X			X
Finland		X			Slovenia	X		X	
Gambia[a]	X	X	X	X	South Africa	X	X		
Georgia	X		X	X	Swaziland	X		X	
Guyana	X				Sweden	X	X		
Hungary	X		X	X	Switzerland	X			
India			X		Trinidad and Tobago	X		X	
Jamaica	X	X	X		Turkey			X	
Japan			X		USA			X	
Jordan	X	X	X	X	Zambia[a]	X	X	X	X
Kuwait			X	X	Total	54	29	44	17

No commitments: Argentina, Aruba, Bahrain, Brazil, Canada, Chile, Colombia, Cuba, Cyprus, Egypt, Gabon, Ghana, Guinea, Haiti, Honduras, Hong Kong (China), Iceland, Indonesia, Israel, Kenya, Liechtenstein, Macao (China), Malta, Mauritius, Morocco, New Zealand, Nicaragua, Nigeria, Paraguay, Peru, Philippines, Republic of Korea, Romania, Solomon Islands, Sri Lanka, Thailand, Tunisia, United Arab Emirates, Venezuela.

EU Member States are counted individually.

In addition to the sectors included above, the definition of medical and health services employed by most WTO Members for scheduling purposes also includes veterinary services and a nonspecified category of other health-related and social services.

[a] Least developed countries.

and quality objectives. The commitments ultimately made for mode 3, possibly the most significant mode for many health services, have possibly been inspired by the intention to overcome shortages of physical and human capital, and to promote efficiency through foreign direct investment and the attendant supplies of skills and expertise.

A comparison accross all schedules and sectors reveals that trading conditions are considerably more restrictive for mode 4 than for other

Table 2. Numbers of WTO Members with commitments on medical, hospital and other health services, July 2000. The 4 modes are defined in Box 1, p. 17, para. 2.

		Medical and dental services	Nurses, midwives, etc.	Hospital services	Other human health services
Total of		54	29	44	17
Market access					
Mode 1	Full	16 (-2)[a]	8 (-1)	15	8
	Partial	11	4	0	2
	Unbound	27	17	29	7
Mode 2	Full	28 (-3)	10 (-1)	38	10
	Partial	24	19	4	6
	Unbound	2	0	2	1
Mode 3	Full	15 (-7)	6 (-2)	16 (-7)	10 (-4)
	Partial	33	22	26	7
	Unbound	6	1	2	0
Mode 4	Full	0	0	0	0
	Partial	49	28	41	12
	Unbound	5	1	3	0
National treatment					
Model 1	Full	19	8 (-1)	18 (-2)	10 (-2)
	Partial	9	4	0	1
	Unbound	26	17	26	6
Mode 2	Full	28 (-2)	10 (-1)	38 (-3)	11 (-3)
	Partial	22	19	4	5
	Unbound	4	0	2	1
Mode 3	Full	18 (-1)	9 (-1)	31 (-25)	9 (-6)
	Partial	31	19	10	7
	Unbound	5	1	3	1
Mode 4	Full	1	0	2 (-1)	0
	Partial	49	28	39	17
	Unbound	4	1	3	0

EU Member States are counted individually.

Partial commitments on market access include commitments that carry any of the six limitations specified in Article XVI:2 of GATS as well as commitments subject to limitations in sectoral coverage (e.g. exclusions of small hospitals or public sector entities) or geographical coverage within the Member's territory, and any other measures scheduled in the relevant column (including domestic regulatory measures for which Article VI might have provided legal cover). Similarly, partial commitments recorded under national treatment may include cases of overscheduling or misinterpretations.

[a] Figures in parentheses are the reduced number of full commitments if horizontal limitations, which apply to all sectors contained in the individual country schedules, are taken into account.

modes. Reflecting the political constraints involved, many Members have limited the entry of natural persons to intracorporate transfers or to experts with special skills that are not domestically available. This contrasts with the conditions for mode 2 (consumption abroad), which tend to be the most liberal. In many cases, governments may have felt that it would be pointless to try influencing demand patterns once consumers had left the countries concerned. Nevertheless, such possibilities may exist. Cases in point include the exclusion of health treatment abroad from domestic consumer subsidies or public reimbursement schemes. Mode 2 trade may prove economically significant in sectors such as education and health, where consumer movements can be viewed as a partial substitute for the movement of personnel under mode 4 and inward direct investment under mode 3. Economically advanced developing countries in the vicinity of major export markets, e.g. Mexico, Morocco, and Tunisia, appear to be particularly well placed for developing such trade, i.e. for attracting foreign patients for longer-term health treatment.

Commitments on individual health services largely follow this general pattern. The highest share of full market access commitments is recorded for mode 2 (consumption abroad); it reaches 85% in the hospital sector. From the standpoint of developing countries, which may be competitive suppliers in this area, it is interesting that virtually all relevant commitments scheduled by developed Members are without limitation (Table 3; see mode 2, hospital services), thus amounting to a legally enforceable guarantee not to deter their residents from consuming abroad. In other subsectors, however, developed countries have tended to use limitations on modes 2 and 3 more frequently than developing countries (Table 4). Concerning mode 4, no WTO Member has undertaken full commitments in any of the four health subsectors. As in virtually all other services, commitments for this mode are subject to limitations and these are generally highly restrictive.

The high percentage of non-bindings for mode 1 in some core health sectors, namely 50% for medical and dental services, 60% and more for nursing and similar services, and 65% for hospital services, may reflect the perception that cross-border provision of these services is not technically possible. Some schedules contain footnotes explaining that a non-commitment under mode 1, in particular for hospital services, is attributable to the unfeasibility of such supplies (Box 1). The question arises, however, as to whether the administrations involved have considered all conceivable possibilities of combining traditional health services with modern communication technologies (Box 2). Telehealth is a case in point. If applied to inpatients, the electronic provision of medical advice across borders could actually be classified as a hospital service, an interpretation not necessarily anticipated by all Members at the time of scheduling. From the legal standpoint this should not be a matter of concern: new technologies would not turn a non-commitment, even if attributed to technical constraints, into a binding access obligation.

Commitments do not have the same importance across all sectors and modes. Their economic value may be high in certain cases, e.g. midwifery services/mode 4, but not in others, e.g.

Table 3. Numbers of WTO developed Members with specific commitments on health services, July 2000. The 4 modes are defined in Box 1, p. 17, para. 2.

		Medical and dental services	Nurses, midwives, etc.	Hospital services	Other human health services
Total (out of 21 schedules)		18	17	15	2
Market access					
Mode 1	Full	4 (-1)[a]	2 (-1)	0	0
	Partial	1	1	0	0
	Unbound	13	14	15	2
Mode 2	Full	5 (-1)	2 (-1)	14	0
	Partial	13	15	1	2
	Unbound	0	0	0	0
Mode 3	Full	2 (-2)	2 (-2)	0	0
	Partial	14	15	15	2
	Unbound	2	0	0	0
Mode 4	Full	0	0	0	0
	Partial	16	17	14	2
	Unbound	2	0	1	0
National treatment					
Mode 1	Full	4	2	0	0
	Partial	1	1	0	0
	Unbound	13	14	15	2
Mode 2	Full	5	2	14	0
	Partial	13	15	1	2
	Unbound	0	0	0	0
Mode 3	Full	1	2	13 (-13)	0
	Partial	16	15	2	2
	Unbound	1	0	0	0
Mode 4	Full	0	0	0	0
	Partial	17	17	14	2
	Unbound	1	0	1	0

EU Member States are counted individually.

[a] Figures in parentheses are the reduced number of full commitments if horizontal limitations are taken into account.

Table 4. Numbers of WTO developing Members with specific commitments on health services, July 2000. The 4 modes are defined in Box 1, p. 17, para. 2.

		Medical and dental services	Nurses, midwives, etc.	Hospital services	Other human health services
Total (out of 44 schedules)		36	12	29	15
Market access					
Mode 1	Full	12 (-1)[a]	6	15	8
	Partial	10	3	0	2
	Unbound	14	3	14	5
Mode 2	Full	23 (-2)	8	24	10
	Partial	11	4	3	4
	Unbound	2	0	2	1
Mode 3	Full	13 (-5)	4	16 (-7)	10 (-4)
	Partial	19	7	11	5
	Unbound	4	1	2	0
Mode 4	Full	0	0	0	0
	Partial	33	11	25	15
	Unbound	3	1	4	0
National treatment					
Mode 1	Full	15	6 (-1)	18 (-2)	10 (-2)
	Partial	8	3	0	1
	Unbound	13	3	11	4
Mode 2	Full	23 (-2)	8 (-1)	24 (-3)	11 (-3)
	Partial	9	4	3	3
	Unbound	4	0	2	1
Mode 3	Full	17 (-1)	7 (-1)	18 (-12)	9 (-6)
	Partial	15	4	8	5
	Unbound	4	1	3	1
Mode 4	Full	1	0	2 (-1)	0
	Partial	32	11	25	15
	Unbound	3	1	2	0

Includes Central and Eastern European transition economies.

[a] The figures in parentheses are the reduced number of full commitments if horizontal limitations are taken into account.

Box 2. Electronic commerce in the health sector: the relevance of GATS

The concept of technological neutrality

As a general rule the introduction of new transport or transmission technologies does not affect WTO Members' rights and obligations under GATT and GATS. For example, there would be no legal basis in GATT, and no reasonable health-related or trade-related justification, for subjecting pharmaceuticals ordered electronically to border treatment different from that of the same consignments ordered via regular mail. Border treatment may include the examination of content, product verification, tariff collection or the seizure or refusal of hazardous products. Similarly, GATS ensures in principle that cross-border trade in services is not affected by the transmission processes employed. For example, except for reasons falling under Article XIV (protection of life and health, etc.), countries would find it difficult under GATS to explain why medical advice provided electronically from abroad is not subject to the same rules as advice conveyed by mail. The underlying concept of technological neutrality in the treatment of like services applies both to scheduled and non-scheduled sectors, as departures are likely to fall foul of the basic MFN obligation.

Application of domestic regulation to electronic supplies

The provision of telehealth services under mode 1 may raise challenging new issues for health administrations. Imagine a foreign supplier that is significantly less qualified or subject to less rigorous controls than domestically established operators. Could the ensuing risks be contained in the same way as risks associated with the use of foreign-produced pharmaceuticals? Possibly not, as there is one important difference: a foreign country's control over its domestic pharmaceutical industry, in application of producer-related and product-related regulations, may be complemented by the importing country's own procedures for the testing and approval of products. Such possibilities do not exist for services that are not standardized and whose quality cannot normally be assessed independently of the production process. However, such process assessment is beyond the importing country's jurisdictional control.

Yet this does not mean that no adequate instruments are available. Possible solutions could consist, for example, of a requirement on domestically established hospitals or doctors to cooperate only with foreign telehealth providers that have been certified by the governments concerned and/or are insured against malpractice with an internationally recognized company. Additional provisions may help to clarify the place of jurisdiction in the event of disputes. Governments in countries operating public health insurance schemes may also make payments contingent on the qualification of the foreign subsuppliers involved. These possibilities also exist for residents seeking reimbursement for health services consumed abroad.

Further considerations

The implications of electronic commerce for the health sector are multifaceted and extend beyond the scope of GATT and GATS. They include issues related to the security and privacy of transactions and to contract and liability law (4).)

midwifery services/mode 1. Likewise, the restrictiveness of similar limitations, e.g. discriminatory subsidies, nationality requirements and land ownership restrictions, can vary widely between sectors. Uncertainties may remain with regard to the measures scheduled in individual cases. For example, licensing requirements for doctors or hospitals, contained in a number of schedules, may be operated for either quality purposes or for the administration of restrictions on access. In the former case, scheduling is not necessary, as quality-related measures do not fall under either the market access provisions of Article XVI or the national treatment obligations of Article XVII (Box 1). In contrast, if quantitative restrictions were involved it would be better to schedule size, time frame and other relevant features rather than the existence of an implementation mechanism.

LIMITATIONS ON TRADE IN HEALTH SERVICES

In order to obtain a full picture of the limitations made by individual Members it is necessary to examine both the horizontal and the sector-specific parts of schedules. Horizontal limitations, which apply across all committed sectors (Box 1), typically reflect economy-wide policy concerns and objectives. These may include foreign exchange restrictions, restrictions on the physical presence of foreign suppliers, foreign equity ceilings, restrictions on the legal form of establishment (e.g. joint ventures only), exclusion of foreign-owned entities from certain subsidies and incentives, or limitations on the acquisition of land or real estate. The relationship between horizontal and sector-specific commitments is not straightforward in all cases, however, and there may be conflicting entries in the two sections. For the purpose of this study the more restrictive or more specific version has been taken into account.

The relatively few limitations applying to health services under modes 1 and 2 (cross-border trade and consumption abroad in health services) are predominantly sector-specific. In the main, they concern the non-portability of insurance entitlements (Table 5). Horizontal limitations—i.e. those applying to all scheduled sectors that may prove relevant for health services—include the non-eligibility of foreign suppliers for subsidies, and restrictions on foreign exchange availability.

The restrictive effects associated with such limitations may be matched by other barriers that are not necessarily recorded in schedules. They include the nonrecognition of foreign licences, qualifications or standards. For example, public health insurers may refuse to reimburse the cost of treatment abroad on the grounds that the services involved have been of lower quality than those offered domestically. It could prove difficult to challenge such practices under GATS. Similar measures employed by private commercial insurers would not even fall under the Agreement. While Article VII entitles Members to enter into recognition agreements or grant recognition autonomously, notwithstanding the potential tension with the MFN obligation, they are under no obligation to develop a liberal approach in this regard. Under the relevant provisions of Article VII:3, governments are merely required, once they grant recognition, not to do this in a manner that would constitute a means of discrimination or a disguised

Table 5. Limitations[a] on insurance portability

Members	Sectors
Bulgaria	Medical and dental services
Latvia and Poland	Medical and dental services; services provided by nurses, midwives, etc.; hospital services
Slovenia and USA	Hospital services

[a] All limitations relate to mode 2 trade, except in the case of Poland, which has also included mode 1 supplies of medical and dental services and the services provided by nurses, midwives, etc.

restriction on trade in services. By end of July 2000, WTO had received 30 notifications of recognition measures under Article VII:4. Of these notifications, 13 pertained to health services inter alia; they were submitted by Macao (China) and several Latin American countries and concerned the recognition of diplomas.

As noted above, mode 3 (commercial presence) and, in particular, mode 4 (presence of natural persons) have drawn the highest share of partial or limited commitments. Most of the limitations scheduled for mode 4 are horizontal, while relatively many of those for mode 3 are sector-specific. In limiting their mode 3 commitments to natural persons, some countries, most of them developed, have reserved the right to restrict the commercial incorporation of foreign health care providers. Frequent market access limitations scheduled under mode 4 concern quantitative restrictions, mainly setting a ceiling on numbers of foreign employees or denying access to all persons not considered to be specialist doctors, etc. Typical national treatment limitations under mode 4 relate to training and language requirements.

Economic needs tests (ENTs) have also been frequently referred to under mode 3 and mode 4, mostly for hospital services but also for medical and dental services. There are few cases where Members have indicated the relevant criteria underlying such tests, for example population density, age structure, death rates and the number of existing facilities. However, a recommendation in the guidelines developed for scheduling purposes in the Uruguay Round calls on Members to indicate the main criteria on which ENTs are based. For example, if the authority to establish a facility is based on a population criterion, the criterion should be described concisely. Unspecified ENTs have been used in particular by economically advanced countries. Given their potential for discretionary application, such entries may come close to a situation in which no commitment exists.

Also of dubious value are the relatively large number of mode 4 commitments that are limited to trainees or intracorporate transferees. Their significance depends essentially on the ability of a foreign supplier to establish a commercial presence under mode 3. However, this tends to be more difficult for exporters of medical personnel in developing countries than for those in developed countries, given current investment patterns, and could prove elusive in those large segments of the health sector where private entrepreneurial activity is either not admitted or commercially unattractive.

Restrictions on foreign equity participation and on permissible types of legal incorporation have been scheduled as market access limitations (Article XVI) for mode 3 in a few cases. Such restrictions may be intended to encourage transfers of technology, skills and expertise; they are mostly contained in the horizontal section of the schedules concerned. Some Members have also made horizontal national treatment limitations reserving the right to require foreign-owned facilities to train nationals. Other horizontal limitations under the relevant provisions of Article XVII include restrictions on the composition of boards of directors and the acquisition of land or real estate, as well as a requirement to grant more favorable treatment to economically disadvantaged groups or regions. The latter requirement may prove to be a potentially powerful instrument for

developing countries to reconcile trade with social equity objectives. However, it may not even have been necessary to provide legal cover for it in schedules.

General references to national legislation are relatively frequent entries in both the horizontal and the sectoral sections. It is difficult in such cases, however, to identify the restrictive or discriminatory elements that would fall foul of Articles XVI or XVII. As noted above, the mere existence of national legislation with adverse effects on market participation, such as licensing requirements or training obligations, does not call for scheduling per se.

Somewhat surprisingly, there are no advance commitments in the health sector providing for liberalization from specified later dates. Such pre-commitments have been used in telecommunications by almost half of the approximately 80 Members that have committed themselves on this sector, in order to map out future paths of liberalization. Precommitments are as legally valid as any other obligations under Article XVI or Article XVII, and may thus serve the same purpose. They may be an interesting policy option in any sector, possibly including health, for which governments have developed longer-term reform strategies allowing for increased private participation. In circumscribing and guaranteeing future market access opportunities, precommitments enable potential new entrants as well as incumbent suppliers to adjust in time.

MFN exemptions are quite rare in health services. Three Members have listed them specifically for medical, dental and/or human health services, and another four have done so for professional services in general. All exemptions are intended to provide legal cover for reciprocity provisions (e.g. potentially affecting the right of foreign suppliers to exercise the medical profession or their qualification for reimbursement under public health insurance schemes). However, a number of MFN exemptions that are not sector-specific may also be relevant for health services, including guarantees under bilateral investment protection agreements or tax preferences for certain nationalities.

Assessment and outlook

The potential for trade in health services has expanded rapidly over recent decades. New telecommunications technologies have reduced the impact of geographical barriers to trade (for example for telediagnosis, teleanalysis and the like), while rising incomes and enhanced information have tended to increase the mobility of potential patients. At the same time, from the standpoint of domestic health authorities, cost pressures associated with aging or fast-growing populations, new medical developments and a widening price/productivity gap in the health sector have underscored the importance of efficiency objectives. Such objectives, in turn, tend to be associated with the existence of competition, including competition associated with foreign market entrants. However, while such trade/efficiency links appear appealing to economists, at least within an appropriate regulatory environment, doubts may remain as to the effects of stiffening competition on other core policy concerns in the health sector, such as quality and the alleviation of poverty.

There are limits to the extent to which governments can influence the level and structure of trade in health services through various instruments. For example, while nonportability of insurance cover may deter many residents from seeking treatment abroad, well-to-do persons are not likely to be discouraged. While a monopoly hospital sector, without foreign investment, may be viewed as instrumental in ensuring fair distribution, cross-border mobility of patients may compensate, at least in part, for the absence of alternatives to domestic supply. The traveling of patients abroad also complicates distributional objectives: do they apply only to the nonmobile part of the population or do they include people who are physically and financially able to seek treatment in foreign hospitals? Furthermore, while administrative restrictions might prevent publicly controlled facilities from offering telemedical services, private suppliers may be eager to fill any ensuing market niches.

From a wider developmental standpoint, additional considerations come into play. Health is among the relatively few service areas in which, subject to various qualifications, developing countries may prove to be competitive exporters, under several modes, including mode 2. Possibly on a basis of inward direct investment, which may in turn benefit from mode 3 commitments, they may be able to attract patients not only from other developing countries (e.g. to Thailand or South Africa from South-East Asia or sub-Saharan Africa) but also from adjacent industrialized countries (for instance to the Caribbean from North America, and to North Africa from Europe). Such possibilities are particularly relevant for countries endowed with sufficient infrastructural resorces, which are able to capitalize not only on locational advantages but also on a range of efficient ancillary service industries. However, this is not necessarily the perspective of low-income developing countries. Their interests tend to hinge predominantly on other modes of supply: mode 3 (i.e. attracting investment inflows) and mode 4 (i.e. sending medical personnel abroad and benefiting from remittances). While the economic value of mode 3 commitments is self-determined, contingent on a country's own schedule, the export opportunities under mode 4 necessarily depend on other Members' policies.

It might be argued that reliance on foreign investment is a more viable development strategy since it is associated with resource inflows, while labor movements abroad are tantamount to a loss of human capital. Are the ensuing remittances sufficient compensation? Empirical studies generally confirm that the majority of migrants from developing to developed countries are better educated than the average workforce remaining behind. This may reflect prevailing policy patterns in the recipient countries, which tend to favor inflows of qualified rather than unqualified persons, as well as a higher propensity of educated and well-informed persons to move abroad. In any event it means that existing migration data tend to understate the corresponding transfer of human capital. However, not all movements imply economically significant losses for the home countries. The critical factors are whether the persons involved have left permanently and whether they would have found, or would find on returning home, employment matching their qualifications (5).

Foreign investment in health facilities represents a positive transfer of resources whose ramifications may reach well beyond the health sector. Indirect effects, including those on growth, income and employment, may occur in related industries such as construction, transport, communication and, possibly, tourism. The attendant developmental benefits may prove difficult to trace empirically, but this does not mean that they are economically irrelevant. Such benefits may have health-related implications. From the standpoint of public health it might prove too narrow a view to consider only the direct effects on a population's health status of increased foreign presence in, for example, a country's hospital sector. Broader routes of causation, leading from the liberalization of trade and investment to development and from development to health, may be equally significant in this connection. Infant mortality is significantly lower and has dropped far more rapidly over the past two decades in Hong Kong, the Republic of Korea, and Singapore than in Indonesia, the Philippines, and Thailand. This may have less to do with the organization of public health than with the resources produced in the former group by trade and investment regimes that in general are more open than those in the latter three countries.

Concerns have been voiced that health sector liberalization may turn out to be a two-edged sword for developing countries. Increased trade in the health sector may benefit hospital operators, health professionals and an urban economic elite, but how would it affect the economically disadvantaged? Such concerns are understandable but they need to be put in a proper perspective.

- First, it is important to bear in mind that GATS does not impose any constraints on the terms and conditions under which a potential host country treats foreign patients. For example, nothing in the Agreement would prevent Members from subjecting the services provided to foreigners that have come for treatment to special taxes or charges. The proceeds, in turn, might be used to enhance the quantity and quality of basic domestic supplies.
- Second, there are no legal impediments in GATS that would affect the ability of governments to discourage qualified staff from seeking employment in the private sector, whether at home or abroad. Deterrent measures might include deposit requirements or guarantees, which would make it financially unattractive for young professionals to capitalize immediately on taxpayers' investment in their education by seeking higher incomes. In addition, there are positive measures that may limit the risk of brain drain: liberalization under mode 3, combined with foreign countries' commitments under mode 2, may help to create domestic employment opportunities and, in turn, dissuade staff from moving abroad.
- Third, it is difficult to see any crowding-out effects, to the disadvantage of resident patients, that could not be addressed through adequate regulation. Such regulation would not normally fall foul of GATS provisions, even in sectors that have been committed without limitation. For example, a country might require all private

hospitals to reserve a minimum percentage of beds for free treatment for the needy, to offer some basic medical services in remote rural areas, or to train staff beyond the number required for the purposes of these institutions. Such measures would withstand examination under both Article XVI on market access and Article XVII on national treatment. If only foreign-owned facilities were subject to such public service obligations the relevant regulation would need to be covered by limitations under Article XVII.

Similar obligations have been discussed at length in the GATS negotiations on basic telecommunications, concluded in February 1997, where social and regional policy considerations also came into play. A Reference Paper developed in this context confirms the right of any government to define the kind of universal service obligation it wishes to maintain and also confirms that such measures would not be regarded as anticompetitive per se. Commitments under the Reference Paper are self-commitments in so far as its content was negotiated in the context of the telecommunications negotiations, while its implementation, through incorporation in schedules, in full or in part, was left to individual countries. About 80% of the WTO Members undertaking commitments on basic telecommunications incorporated the Reference Paper. These Members are self-committed to administering their universal service obligations in a transparent, nondiscriminatory and competitively neutral manner and to ensuring that they are not more burdensome than necessary for the kind of service envisaged.

It could be argued that these provisions do not add a lot to what already exists in GATS Article III on transparency, Article VI on domestic regulation, Article XVI on market access and Article XVII on national treatment. However, their inclusion in the Reference Paper might have reassured telecommunications administrators and regulators who, for understandable reasons, were perhaps not entirely familiar with the terms and structure of GATS. A common interpretation of existing rules and, in some cases, specification of additional disciplines should be of particular interest to developing countries as it would allow them to economize on negotiating resources. It may be worth considering such an approach in health services as well.

Given the basic social and infrastructural functions conferred on core service sectors, including health, there is certainly no point in talking policymakers into hasty liberalization. The consequences should be carefully considered, and this may well indicate a need for new regulation to accompany the phasing in of external competition. In a public monopoly environment the production, financing, regulation and control of a service tend to go hand in hand, whereas the move toward competitive systems necessarily implies a separation of tasks and functions. Liberalization may therefore presuppose reregulation in order to meet the multiplicity of legitimate objectives involved. This is a challenging task, not least for developing countries lacking regulatory experience. However, there is nothing to prevent administrations from joining forces to exploit possible synergies and/or mandating competent international organizations to propose

model solutions. Regulatory approaches developed for telecommunications in recent years, under the auspices of the International Telecommunication Union, could inspire work in WHO and comparable bodies in other areas as well. The technological and economic forces working towards global market integration are unlikely to leave the health sector unaffected, and timely action by governments would seem to be desirable.

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