

The General Agreement On Trade In Services: Implications For Health Policymakers

To what extent does the GATS allow governments to regulate health services providers?

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ABSTRACT: The General Agreement on Trade in Services (GATS), created under the auspices of the World Trade Organization, aims to regulate measures affecting international trade in services—including health services such as health insurance, hospital services, telemedicine, and acquisition of medical treatment abroad. The agreement has been the subject of great controversy, for it may affect the freedom with which countries can change the shape of their domestic health care systems. We explain the rationale behind the agreement and discuss its scope. We also address the major controversies surrounding the GATS and their implications for the U.S. health care system.

EVER SINCE THE DEMONSTRATIONS in late 1999 against the World Trade Organization (WTO) in Seattle, many Americans have become attuned to the controversial effects of globalization. Those concerned about health have largely directed their attention to the WTO's Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement, focusing on the ways in which the agreement might prevent developing countries from acquiring essential medicines such as antiretroviral drugs for HIV/AIDS treatment. However, another WTO agreement may also be important for health policy: the General Agreement on Trade in Services (GATS). The GATS is designed to regulate measures affecting international trade in services—including health services such as health insurance, hospital services, telemedicine, and acquisition of medical treatment abroad. The agreement has been the subject of great controversy, for it may affect the freedom with which countries can change the shape of their domestic health care systems.

Critics have charged that the GATS requires privatization of health services,

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prevents governments from regulating players in the health sector, and generally hinders countries' ability to determine the shape of their domestic health care systems democratically.¹ This recent severe criticism of the GATS has raised the prospect of adverse consequences of WTO agreements for developed countries and has sparked concerns that the GATS could diminish Americans' freedom to change the shape of their health care system.

In this paper we show that there is little clear evidence of such adverse consequences, given the conditions presently existing under the GATS. However, the U.S. role in further specifying the agreement, as well as the additional commitments the United States makes, will determine the GATS' ultimate impact on the U.S. health care system. It is therefore important for U.S. health policymakers to be aware of, and to influence, any future agreements that the United States makes as part of its trade negotiations. One important aim of this paper is to provide background information on the GATS that will enable health policymakers to play a constructive role in future trade negotiations.

The Rationale Behind The GATS

The GATS, negotiated by some 120 governments throughout the world, came into force in 1995.² Analogous to treaties that promote free trade in goods, the GATS aims to create a favorable climate for trade in services and thereby to promote efficiency and economic growth. It does so by allowing countries to make binding commitments to reduce various trade barriers. For many, the idea of services' being traded across borders might seem strange. Unlike trade in goods, the exchange of a service between provider and consumer is naturally thought of as taking place across a short distance. However, as technology has advanced, education, finance, technology, and health services have entered the global marketplace.

International trade in health care services is only beginning. Already, through telemedicine, doctors in one country can read x-rays and make diagnoses for patients living elsewhere. Telesurgery allows doctors to perform surgery on a patient in an entirely different location. In a world where technology and medical expertise are increasingly more widely distributed, opportunities to acquire cheap and yet comparable treatment from physicians abroad may soon abound. As U.S. medical costs rise, with physician fees constituting the bulk of these costs, there is reason to think that insurance companies may take advantage of this opportunity.

The GATS will regulate all existing and future trade in health services. The agreement covers health services that fall within one of the four different modes of supply it defines: (1) cross-border trade (for example, a U.S. physician makes a telediagnosis of a U.K. patient); (2) consumption abroad (for example, a U.S. resident goes to Canada to obtain health services); (3) commercial presence (for example, a resident of India obtains health services from a hospital owned in the United States but located in India); and (4) the presence of natural persons (for example, a surgeon from Thailand performs an operation in the United States).

While these are only a few examples, they nevertheless show that a wide range of existing and potential trade in health services falls within the agreement's scope.

Rules Of The GATS

The GATS contains two kinds of rules: conditional and unconditional. The conditional rules apply to a given service sector only if a country has formally and explicitly committed to maintaining a certain degree of openness to trade in that sector. The unconditional rules apply to all of a country's service sectors, simply by virtue of its having signed the GATS.

Of the various unconditional rules that apply to all trade in services, two are most important. First, members must not discriminate between suppliers from different countries. Under the so-called Most-Favored-Nation (MFN) Treatment clause, a country must instead apply the same conditions and privileges to service suppliers from all countries. For example, a country cannot allow only French insurance companies to enter the insurance market while disallowing Swiss competitors. Second, countries must maintain transparency with regard to their trading practices. Specifically, they must inform other members and the Council for Trade in Services about any new laws or changes to existing laws and regulations that might substantially affect trade in services covered by their specific commitments under the GATS.³

The GATS allows individual countries to decide which sectors, and which subsectors within them, they want to commit to the conditional rules, which are more specific and demanding than the unconditional rules. This allows countries to decide what degree of openness to trade they wish to maintain in a particular service area. Countries vary both in the number and choice of sectors or subsectors they have committed and in the degree of openness to trade they have agreed to maintain in committed sectors.

This variation can be seen in the commitments countries have made within the four health subsectors: medical and dental services, services provided by medical personnel, hospital services, and other health and human services. Canada has not made any health services commitments, and the United States has made only one commitment in the hospital services sector. By contrast, least-developed countries such as Burundi, Sierra Leone, and Zambia have made commitments in three or more health subsectors. In general, countries with government monopolies in the health services sector, which either prohibit private suppliers or make private entry commercially nonviable, have tended not to make health services commitments under the GATS.⁴ On the other hand, health insurance is treated differently under the GATS. It falls within the financial services sector, rather than the health services sector. Overall, seventy-six WTO members (including the United States, Mexico, Canada, and the European Union member states) have made commitments in health insurance.⁵

When a country fully commits a given sector under the GATS, it accepts two

types of legal obligations. First, it agrees to grant “market access” to foreign competitors. This means refraining from establishing barriers to trade, such as quotas that limit the number of providers of a given service (such as hospitals, physicians, and insurance companies) or the volume of service supplied by each provider (including number of beds, doctors, and consumers).⁶ Second, in fully committing a sector, a country also agrees to treat foreign competitors no less favorably than it treats service suppliers from its own country. For example, under this “national treatment” provision, a country could not exclude foreign-owned hospitals from subsidies or benefits created as part of domestic policy.⁷

However, countries also have the option of establishing limits on any market access or national treatment commitments they make. For example, in the hospital sector the United States has granted market access but has reserved the right to establish “needs-based” quotas, which allow it to assess how many hospitals are needed in a given area and to limit their number accordingly. Few countries have made “full” commitments in the health service sector—that is, commitments without any limitations.

In general, countries have tended to make commitments in sectors where foreign suppliers were already present, thus protecting the existing degree of openness to trade, rather than committing themselves to greater liberalization. However, each commitment is part of a larger negotiated trade package. Thus, the reasoning behind the commitments made in any given sector cannot be fully understood without looking at the broader negotiation process.

Controversies

Although the GATS is designed to bring about fair international trade in services, it has its detractors. Some of the charges levied against the GATS are that it inhibits governments from shaping their own health care systems, threatens government-funded or -provided health services, undermines domestic regulation, and generally fails to allow governments to protect public health.⁸

Critics of the GATS cite different parts of the agreement as support for these claims. Without discussing those parts of the agreement in detail, we address three main questions at the heart of their criticisms: (1) How are public services affected by the GATS? (2) Does the GATS impede countries’ ability to pursue national objectives by regulating services and service providers? (3) Does the GATS unduly restrict the scope for states to determine the shape of their health care systems democratically?

■ **Status of public services under the GATS.** A central question is whether publicly provided health services are excluded from the agreement and its rules. Article I(3) of the GATS specifies that the agreement excludes services supplied in the “exercise of governmental authority,” defined as services supplied neither “on a commercial basis” nor “in competition with one or more service suppliers.” It is not clear how these categories are to be interpreted. So while certain public health services

clearly qualify for this exemption, it is unclear whether others do. Does the exemption still apply, for example, in health systems where government providers compete with one another (like the United Kingdom's) or where health insurance is supplied competitively by a mix of for-profit and nonprofit administrators (like Germany's)?

This vagueness in the rules leaves open the possibility that publicly provided health services supplied within a broader market structure might not be exempt from the GATS.⁹ Is this a reason for concern? Some experts emphasize that even if public services are not exempt from the GATS, countries still retain the right to regulate all providers, public as well as private.¹⁰ In essence, they contend that as long as countries can regulate, the question of how widely the GATS applies is unimportant.

If governments can fully regulate service providers, there may indeed be little cause to be concerned about the status of public services under the GATS. However, the question of the extent to which governments can regulate is itself controversial.

■ **Governmental regulation.** One of the most heated GATS controversies concerns the extent to which the GATS allows governments to regulate health services providers. The GATS preamble specifically recognizes “the right of members to regulate and to introduce new regulations in the supply of services within their territories to meet national policy objectives.” Nevertheless, many believe that Article VI provides an opening through which legitimate domestic health policy objectives can be sacrificed to trade imperatives. Critics charge that the GATS would “outlaw the use of non-market mechanisms such as subsidization, universal risk pooling, solidarity, and public accountability in the funding and delivery of services.”¹¹

Although it is controversial how free its signatories are to regulate, the GATS seems to allow countries to impose domestic regulations on services, if they do so in a nondiscriminatory way. For example, a country like the United States that permits both foreign and domestic physicians to work in the health care system could not, in the name of health, arbitrarily allow only physicians educated in Country A to practice if their training was comparable to that of physicians from Country B. What the United States could do is to require all physicians entering the United States to pass a standard licensing examination, with those who failed—even if this included everyone from Country A—being required to undergo further training. Regulations designed to give preference to domestic suppliers or to one particular trading partner, in ways not justified by the protection of health, are not acceptable.

Article VI(4) of the agreement provides for the development of a test to ensure that regulations are “not more burdensome than is necessary to ensure the quality of services.” This so-called necessity test is meant to ensure that regulations are “based on objective criteria such as competence and ability to supply a service” and that licensing requirements are not used as a surreptitious means to restrict trade in services. Thus, while the GATS recognizes a government's obligation to

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protect the health of its citizens, the necessity test aims to ensure that governments do not “invoke health reasons as a pretext to evade substantive obligations, without credible justification.”¹²

It is hard to say whether Article VI will seriously impede domestic regulation. The simple reason is that the necessity test for which it provides has yet to be developed and tested. (In addition, very few cases arising from similar tests in other WTO agreements have been brought before a WTO dispute settlement body.)¹³ Before a necessity test can be formally introduced, however, it has to be negotiated, and each member state has to approve it. Policymakers concerned about the influence of the GATS on domestic regulation should therefore remain attuned to the negotiations surrounding the development of a test under Article VI.

Two issues in these negotiations are worthy of special attention. One is whether the necessity test to be proposed will apply to all service sectors unconditionally or merely to sectors in which a country has made specific commitments. The other concerns where the burden of proof under the proposed test will lie—with the country charged with unnecessarily restricting trade or with the country bringing the charge to the WTO? The right to regulate would be less seriously threatened by a necessity test that applied only to specifically committed sectors and also assigned the burden of proof to the plaintiff country.

■ **Imposition on national autonomy and democratic legitimacy.** Finally, a persistent criticism of the GATS has been that it impinges on national autonomy by limiting the ways in which countries can structure domestic health care systems. The premise underlying these critiques is that decision making about the structure of domestic health systems should be left to each country on its own and should not be restricted by rules or actors outside of that country.

Although it is true that the GATS limits the policies countries can maintain in sectors committed under the agreement, countries themselves choose whether or not to participate. Furthermore, countries that sign the agreement are still free not to commit particular sectors, such as health or insurance, or to commit them only partially. Consequently, the various obligations arising under the GATS are best seen as ones that individual countries impose on themselves through their own sovereign decisions. It is therefore incorrect to say that GATS obligations unduly impede national autonomy.

Whether these obligations infringe upon the democratic legitimacy of a domestic health system, however, is a separate question. Not all exercises of national sovereignty are democratically legitimate, as the familiar example of a fully sovereign dictatorship shows. Of course, some governments are obviously democratic—for example, the U.S. government—and so it may be reasonable to assume that their

ordinary legislative decisions are legitimate. Still, this assumption is not always justified. Some decisions, even by Congress, are not regarded as legitimate unless they are subjected to special forms of further democratic scrutiny—for example, decisions to amend the Constitution (or to adopt it in the first place). Among other reasons, these decisions are special because they remove certain matters from ordinary legislative control and thereby restrict later exercises of legislative power in ways that are then very difficult to undo.

At least some of the obligations imposed by the GATS are analogous to constitutional obligations, as they similarly restrict later exercises of domestic legislative power in matters of fundamental importance (such as health), in ways that are difficult to undo. To gain democratic legitimacy, therefore, sovereign commitments under the GATS should also be subject to special forms of further democratic scrutiny, such as popular referenda or supermajoritarian ratification requirements.

The original U.S. decision to sign the GATS was approved by Congress, along with the other Uruguay Round agreements, in late 1994. None of these agreements was formally ratified as a treaty, although the Senate did in fact give its approval by more than the two-thirds majority that treaties require. The U.S. initial commitments in specific sectors were approved as part of the same vote. Further U.S. commitments to liberalize additional sectors under the GATS will likewise simply be made by the U.S. Trade Representative, with the overall result of a negotiating round being subject to the ordinary approval of Congress as a package deal.¹⁴

From the standpoint of democratic legitimacy, the Trade Representative's power to make (additional) commitments under the GATS should be subject to some special form of democratic scrutiny, beyond the ordinary approval of Congress. Since these commitments are precisely what triggers basic obligations under the conditional rules of the GATS, decisions to make them should be regarded as matters of fundamental importance, rather than as merely technical decisions. They are on a par with the decision to sign the GATS in the first place.

Of course, the question of exactly what scrutiny decisions to make (further) commitments under the GATS must receive to be democratically legitimate is one that individual countries must answer for themselves. U.S. citizens and policymakers are the ones to determine—and so they should ask themselves—whether the existing level of scrutiny of the U.S. Trade Representative's powers is acceptable. Although we focus on the GATS here, this issue is also relevant to other international agreements, insofar as they concern issues of fundamental importance and similarly restrict the exercise of domestic legislative power.

Implications For The U.S. Health Care System

Having signed the GATS, the United States has undertaken its unconditional obligations with respect to all service sectors of the economy, including health. These obligations include those of transparency and nondiscrimination. Addi-

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tional obligations flow from the specific commitments the United States has made—for example, to granting market access to foreign health insurance providers and to treating both domestic and foreign suppliers equally. The United States has also agreed to withhold preferential national treatment and to grant market access to hospital service providers, reserving the right to establish quotas on the number of hospitals allowed to enter U.S. markets.¹⁵

The market access commitments are particularly important. Since the United States has agreed to open the health insurance sector fully to foreign providers, it cannot change its mind without cost. For example, should it decide to establish or expand monopoly provision of health insurance services in areas formerly open to foreign providers, it will be obligated to compensate countries whose trade in services is harmed by this change. Compensation may take various forms. The United States could liberalize equivalent service sectors in exchange, or, as a last resort, the country whose providers are affected by the change could withdraw equivalent market access from U.S. providers.

The commitment to treat foreign and domestic providers equally is also important. Because the United States has not imposed any relevant national treatment limitations on its commitments in the hospital and health insurance sectors, any further subsidies it now makes must be extended equally to both foreign and domestic suppliers should it decide to further subsidize insurers or hospitals.

The following case illustrates how these commitments could have practical implications. Congress has recently enacted a major reform of the Medicare program. In part, this reform opens the door to allowing private health insurance companies (including foreign companies) to compete against the government insurance provider within the Medicare program. To begin with, competition will be allowed on a pilot demonstration basis. But if private competition within Medicare is retained after the demonstration period, the GATS will then restrict the United States’ freedom to reverse course, should the reform come to be considered a mistake (as some now contend). In particular, if the United States wanted later to eliminate competition that had become established within Medicare and thereby to restore a government insurance monopoly for elderly Americans within Medicare, it would likely be required under the GATS to provide compensation to all countries whose health insurance firms were harmed by the reversal.

THE ACTUAL IMPACT OF THE GATS on the U.S. health care system will be largely determined by the way in which the agreement is further specified and by future U.S. commitments. Health policymakers can play an active role in shaping those future commitments. To ensure that the ambiguities in the

agreement are resolved favorably, health policymakers should establish further relationships with the U.S. Trade Representative. Furthermore, by ensuring that future GATS commitments reflect the desired shape of the health care system, health policymakers can avoid losing policy options later as a result of GATS commitments that have been made unwittingly. An educated and active health care lobby can also ensure that health sector commitments are not used as bargaining chips in the broader trade negotiation process.

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NOTES

1. See, for example, S. Sinclair, *GATS: How the WTO's New "Services" Negotiations Threaten Democracy* (Ottawa: Canadian Centre for Policy Alternatives, 2000); M. Sanger, *Reckless Abandon: Canada, the GATS, and the Future of Health Care* (Ottawa: Canadian Centre for Policy Alternatives, 2001); A.M. Pollock and D. Price, "Rewriting the Regulations: How the World Trade Organisation Could Accelerate Privatisation in Health-Care Systems," *Lancet* 356, no. 9246 (2000): 1995–2000; and A.M. Pollock and D. Price, "The Public Health Implications of World Trade Negotiations on the General Agreement on Trade in Services and Public Services," *Lancet* 362, no. 9389 (2003): 1072–1075.
2. For the text of the GATS, see www.wto.org/english/docs_e/legal_e/26-gats_01_e.htm (11 March 2004).
3. GATS, Articles II and III.
4. R. Adlung and A. Carzaniga, "Health Services under the GATS," *Bulletin of the World Health Organization* 79, no. 4 (2001): 356.
5. WTO Council for Trade in Services, "Health and Social Services: Background Note by the Secretariat," 18 September 1998, Table 3, www.wto.org/english/tratop_e/serv_e/w50.doc (11 March 2004).
6. Adlung and Carzaniga, "Health Services under the GATS," 356.
7. *Ibid.*, 354.
8. See Sinclair, *GATS*; Sanger, *Reckless Abandon*; Pollock and Price, "Rewriting the Regulations"; and Pollock and Price, "The Public Health Implications."
9. M. Krajewski, "Public Services and the Scope of the GATS," May 2001, www.ciel.org/Publications/PublicServicesScope.pdf (11 March 2004). Compare WTO Council for Trade in Services, *Health and Social Services*, sec. 38.
10. A. Mattoo, "The GATS and Trade in Health Services" (Paper presented at the NIH Conference on Globalization, Justice, and Health, in Washington, D.C., 4 November 2003).
11. Pollock and Price, "Rewriting the Regulations," 1995.
12. R. Adlung, "Preliminary Comments on Pollock and Price" (Unpublished paper, WTO Trade in Services Division, 2003).
13. WTO Working Party on Domestic Regulation, "'Necessity Tests' in the WTO: Note by the Secretariat," 2 December 2000, docsonline.wto.org/DDFDocuments/t/S/WPDR/W27.doc (11 March 2004).
14. D. Leebron, "Implementation of the Uruguay Round Results in the United States," in *Implementing the Uruguay Round*, ed. J. Jackson and A. Sykes (Oxford, U.K.: Clarendon Press, 1997).
15. For a list of the current U.S. commitments, see tsdb.wto.org/wto/Public.nsf/FSetPredefinedReport?OpenFrameSet (11 March 2004).