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Navigating between the Poles: Unpacking the Debate on the Implications for Development of GATS Obligations relating to Health and Education Services

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I. INTRODUCTION

Differences of opinion are stark regarding the implications of the General Agreement on Trade in Services (GATS) for public services like health and education in developing countries. Some believe that GATS poses no threat at all to these essential services and, in some circumstances, may contribute to their more effective delivery and regulation. Others are vehemently opposed to trade liberalization commitments of any kind in these areas and view GATS as a significant threat to the effectiveness and even the viability of national health and education systems.

GATS proponents emphasize that GATS allows countries to tailor their commitments to calibrate the level of obligation in ways consistent with national policy objectives. They point out that there is no obligation on any World Trade Organization (WTO) Member to accept the higher tier of GATS obligations, including national treatment and market access, for any particular service and the basic obligations applicable to all services, like most-favoured-nation (MFN) treatment, do not represent any meaningful limitation on regulatory flexibility. In any case, GATS does not apply to most publicly delivered health and education services. These are completely excluded from the scope of all GATS obligations. Most GATS proponents readily admit the fundamental importance of equitable access and other non-commercial goals that inform national policies in health and education. They assert,

however, that GATS commitments to trade liberalize not only can be compatible with such goals but can make their achievement more likely.[1]

Many GATS critics start from a philosophical objection to a trade regime in which health and education services are treated like commodities. Trade liberalization commitments are viewed as serious constraints on the ability of developing country governments to achieve equitable access to basic health and education services and other objectives sought to be fulfilled by government schemes governing the regulation and delivery of these services. In particular, liberalization commitments are seen as contributing to the development of two-tier markets in health and education under which public services will be undermined and developing country citizens who are the poorest or in rural areas will see a diminution of badly needed health and education services so that already better off and better served urban segments of the population will benefit.[2]

GATS critics assert that GATS vaunted flexibility is constrained in practice for developing countries by the power dynamics of trade negotiations and capacity limitations that systematically disfavour developing countries. GATS obligation to engage in successive rounds of negotiations with a view to progressively liberalizing trade in services ensures that there is ongoing pressure to improve liberalization commitments. The critics argue that any flexibility that may be accorded in the architecture of the agreement is lost when commitments are undertaken. In their view, GATS commitments lock in liberalization programmes such that subsequent policy reform to return to local private or public delivery is precluded. The dynamic nature of regulation and services delivery in health and education combined with the uncertain scope of GATS obligations make locking in a specific approach to regulation and delivery inappropriate and undesirable.

The reality for developing countries, of course, is much more complex than either of these polar positions suggests. Before deciding on what GATS commitments to undertake in health and education, developing countries must make prior policy choices regarding how

[1] Examples of commentators who, in general, argue in favour of this view include R. Adlung, 'The GATS Negotiations: Implications for Health and Social Services' (2003) 38 *Intereconomics* 147; P. Sauvé, *Trade, Education and The GATS: What's In, What's Out, What's All The Fuss About?* (2002).

[2] E.g. South Africa's Minister of Education, Kamal Asmal, once warned the South African parliament that 'We must avoid at all costs a GATS in education,' quoted in L. Mabuza, 'Who's In and Who's Out? Country Responses to Education and GATS' in *Report of the 15th CCEM Preliminary Meeting on Education and the General Agreement on Trade in Services: What Does the Future Hold?* (May 2003). A similar view was expressed in the 'Porto Alegre Declaration' by a conference of Latin American and Iberian universities in Porto Alegre, Brazil on 27 April 2002.

much private-sector participation to permit in the delivery of these services. Both health and education are basic government responsibilities and states are extensively involved in regulating, funding, and delivering services in these areas. But governments everywhere are considering, or are actually engaged in, reforms to privatize public services or commercialize services delivery in an effort to improve accessibility and control costs. Whether and how to move forward with such reforms are fundamental and often hotly debated domestic issues. Developing country governments must assess the costs and benefits of privatization and commercialization in health and education services measured against the achievement of their development objectives. The desirability and impact of privatization and commercialization on development in each country will depend very much on local conditions including the state's capacity for effective domestic regulation of private-sector suppliers.

One question for developing countries in this regard is whether there would be benefits resulting from permitting foreign firms to provide privatized or commercialized services. For example, countries must determine the extent to which opening health and education sectors to foreign investors would lead to more money flowing to improving health and education facilities and better access to desperately needed health and education services than if investment were limited to domestic sources.

A secondary question for developing countries that have decided to liberalize their markets for health and education services is to determine the prospective contribution of GATS commitments in health and education services to obtaining the net benefits of trade liberalization. Many states are successfully liberalizing their regimes relating to health and education services without making GATS commitments to do so. In the current round of GATS negotiations there is little pressure on developing countries to adopt stronger commitments in these areas from WTO Members. At the same time, there is some uncertainty regarding both the scope and nature of GATS obligations and the trade benefits associated with making specific GATS commitments in these sectors. In this context, many developing countries are understandably reluctant to undertake commitments that would limit their future policy options.

This chapter sketches the by now familiar outlines of the debate on the liberalization of public services in developing countries focusing on health and education. It then provides a brief overview of the relatively limited existing GATS commitments in these sectors and the low priority attached to improving commitments in the current negotiations. The final sections of the chapter look at why there is so

little interest in GATS commitments among WTO Members and suggest some possible strategies for making the GATS more relevant to improving the regulation and delivery of health and education services in developing countries.

II. AN UNSCANDALIZED DISCUSSION OF TRADE LIBERALIZATION IN HEALTH AND EDUCATION

A. Introduction: health and education services under the GATS

GATS applies to all measures affecting trade in health and education services. The only true exclusion from the application of the agreement is for services 'supplied in the exercise of governmental authority' which would include, at least, health and education services provided exclusively by the state without charge to its citizens. In terms of obligations, GATS creates both a general framework that applies to all services subject to the agreement and a set of additional obligations for each WTO Member that apply to the treatment of particular services activities that the Member has agreed to list in a national schedule of commitments.

The most important general rule is the obligation to grant MFN treatment to foreign services and service suppliers of other Members. This means that Members must treat services and service suppliers from other Member states no less favourably than those from any other country. For this obligation to apply, services or the service suppliers must be in similar categories. In the language of the WTO agreements, they must be 'like'.

For every services activity that is listed in its national schedule, a Member commits to a higher level of obligation. A Member must grant foreign services and service suppliers national treatment (meaning treatment no less favourable than the treatment of like domestic businesses) and cannot impose certain restrictions on market access. The national treatment and market access obligations for listed sectors may be circumscribed by express limitations inscribed by each Member in its schedule.

As well, for listed sectors, each Member must ensure that all measures of general application are administered in a reasonable, objective, and impartial manner. Measures relating to qualification requirements and procedures, technical standards, and licensing requirements in these sectors cannot nullify or impair the Member's specific commitments in listed sectors by imposing requirements or standards not based on objective and transparent criteria, such as competence and ability to

provide the service, or that are more burdensome than necessary to ensure the quality of the service. In the case of licensing procedures, the procedures themselves must not be a restriction on the supply of a service.

GATS contains no definition of health or education services. Most WTO Members scheduled their specific commitments for particular services with reference to the Services Sectoral Classification List developed during the Uruguay Round of negotiations which is based on and refers to the categories in the United Nations Provisional Central Product Classification.[3] In the Classification List, 'Health related and social services' is a distinct category of activity including hospital services and an undefined array of 'other human health services not elsewhere classified' that includes the services of long-term residential health-care facilities and ambulance services and likely extends to public health and health promotion, laboratory services, and diagnostic services. The services of health professionals, including physicians, dentists, nurses, and others, are listed under 'Business services'. Health insurance is categorized as a financial service. Education services referred to in the Classification List include not only primary and secondary education and higher education at colleges and universities, but also adult education and 'other education'. This last category likely encompasses a wide variety of commercial training programmes and in-house training by businesses. The Classification List provides little guidance on how to define education services beyond these basic categories.[4]

B. The national policy context for trade in health and education

One of the distinctive features of national regimes governing health and education services, as compared to most other services, is that they must be responsive to a complex matrix of important policy objectives and involve a high level of state engagement as a funder, regulator, and service provider.[5] These characteristics make health and education services particularly challenging to address in a trade agreement, like

[3] GATT, *Services Sectoral Classification List*, Note by the Secretariat (10 July 1991), GATT Doc. MTN.GNS/W/120. This classification is based on the United Nations, *Provisional Central Product Classification*, Statistical Paper Series M No. 77 (1991). Most Members identified the services activities with respect to which they were assuming obligations by reference to the Secretariat's classification and the corresponding categories in the Provisional CPC Classification, though, as noted below, many customized their commitments in health and education by adopting additional distinctions.

[4] The Provisional CPC (*supra* n. 3) adds little in the way of elaboration. See Provisional CPC code 92.

[5] The WTO Secretariat describes health as operating at the 'borderline between public and private spheres': WTO, Council on Trade in Services, Health and Social Services: Background Note by the Secretariat (1998) S/C/W/50 at 8.

GATS, that creates disciplines applicable across a broad range of services activities.[6]

Equitable access to a basic level of health and education is widely considered to be a human right and a fundamental responsibility of the state. Public policy in health and education is related not just to quality, the central preoccupation of policy-making in most other services areas, but also to a variety of other objectives including equitable access to services and consumer protection as well as the efficient allocation of resources.[7] In health, the greatest challenge for government policy-makers in all countries continues to be how to manage escalating expenses resulting from increased costs of treatment and demographic shifts while ensuring the quality and accessibility of treatment. Education policy must deal with cost pressures, consumer protection, and access concerns as well but must also safeguard the role of education as the primary mechanism for the transmission of national values and culture and in preparing a nation's people for citizenship.

For developing countries especially, improvements in health and education are closely linked to economic development. With respect to health, the recent report of the World Health Organization (WHO) Commission on Macroeconomics and Health has demonstrated the relationship between health and poverty reduction. The Commission found that better health contributes to:

- higher rates of labour productivity;
- higher rates of domestic and foreign investment;
- improved human capital;
- higher rates of national savings.[8]

The contribution of education to development is also well established.[9] Indeed improvements in health and education outcomes are related. For example, education is one of the most effective means of

[6] That is not to say that other services do not operate in an environment defined by important non-commercial policy considerations and complicated regulatory structures. Financial services and telecommunications are examples. The direct human impact and level of public-sector engagement in regulation and direct delivery in every country, however, make education and health distinctive.

[7] D. Lipson, Comments, *OECD–WB Services Experts Meeting*, 4–5 March 2002.

[8] World Health Organization, Commission on Macroeconomics and Health, *Investing in Health for Economic Development*, online at http://www.cid.harvard.edu/cidcmh/-CMHReport.pdf; see also World Bank, *Development Report for 2004: Making Services Work for Poor People* ch. 8, online at http://econ.worldbank.org/wdr/wdr2004/-text-30023/.

[9] UNESCO/OECD, *Financing Education—Investments and Returns, Analysis of the World Education Indicators 2002 Edition* (2003); World Bank, *supra* n. 8 ch. 7.

combating the transfer of HIV/AIDS.[10] In recognition of the key role of health and education in development, improvements in both areas are implicated in the first six of the eight millennium development goals set by the United Nations (UN).

Another distinctive attribute of the health and education sectors is that both are characterized by market failures. Simply stated, this means that because of a lack of consumer resources, information asymmetries between consumers and providers of health and education services and other market distortions, private-sector suppliers on their own would not supply health or education services at minimally necessary levels of quantity and quality.[11]

The combination of these factors has meant that a very large segment of both health and education services are delivered or funded, in whole or in part, by the state in all countries. Approximately 50 per cent of health services in developing countries are publicly funded.[12] Public spending on education varies substantially from one country to the next but represents more than one-half of total education expenditure in every country.[13]

In almost all developing countries, the extensive presence of the state is complemented by some level of private funding and delivery of health and education services. In part, this is because of the inability of developing country governments to provide fully adequate services in these areas. Private and public systems may operate in parallel but in most developing countries are closely intertwined. Typically some form of public funding is provided to support the private delivery of basic health and education services. The role of the private sector is expanding in many jurisdictions as governments seek new ways to enhance service delivery and manage escalating costs, such as by privatizing state-run services or introducing competition or other commercial considerations into services delivery. Because of the compelling and varied policy objectives associated with health and education and the state's role as a major funder, private services in these areas are closely regulated.

[10] OECD, 'Poverty and Health in Developing Countries: Key Actions' in *OECD Observer* (November 2003).

[11] C. Blouin, 'Economic Dimensions and Impact Assessment of GATS to Promote and Protect Health' in C. Blouin, N. Drager, and R. Smith (eds), *Trade in Health Services, Developing Countries and the General Agreement on Trade in Services (GATS): A Handbook* (2004).

[12] WTO Secretariat Note on Health and Social Services, *supra* n. 5.

[13] UNESCO, *Global Education Digest 2004: Comparing Education Statistics Across the World* (2004). Within OECD countries as much as 98 per cent of education spending is public, though the average is around 88 per cent. Percentages in developing countries are typically lower, but remain substantial.

C. Growth in health and education services trade

Despite the extensive role of the state, both health and education services are increasingly traded. Trade in services means services delivered in any of the four modes of supply contemplated in GATS:

- Mode 1—cross-border supply: a service is supplied from the territory of one WTO Member into the territory of any other Member such as over the telephone;
- Mode 2—consumption abroad: a service is supplied in the territory of one Member to a service consumer of any other Member where the service consumer travels to the supplier's country to consume the service;
- Mode 3—commercial presence: a service is supplied by a service supplier of one Member through a commercial presence in the territory of any other Member;
- Mode 4—presence of natural persons: a service is supplied by a service supplier of one Member through the presence of natural persons of that Member in the territory of any other Member.

Health-care and education services may be traded in all four of these modes of supply. Though reliable global data on the magnitude of such trade is not available, existing evidence suggests that it is modest but growing strongly. In part, this has been driven by experiments in many countries with increased private-sector delivery, including delivery by foreign suppliers. While most exporters are developed countries, a growing number of developing countries, including Cuba, India, Jordan, and Thailand, are engaged in exports of health and education services.

The most important mode for international trade in both health and education services is consumption abroad (GATS Mode 2). Large numbers of students attend foreign education programmes, especially those offered by universities and other higher education institutions. China is the source of the largest number of students studying abroad. Many students from other developing countries, including India, Indonesia, Malaysia, Mexico, Pakistan, and Thailand, also study outside their countries of origin.[14] As well, every year more and more patients are visiting other countries to consume health services. An increase in the number and mobility of affluent consumers in developing countries and their rising expectations regarding service quality is driving growth in Mode 2 imports into developing countries as these consumers travel abroad for health and education.

[14] In 2002, there were 2.3 million foreign students studying at higher education institutions in the OECD countries, compared to 1.47 million in 1999.

In the area of health services, exports from developing countries through GATS Mode 2 are becoming increasingly significant. Interest in non-traditional medicine and competitive pricing of high-quality services in some developing countries has encouraged developed country consumers to travel to developing countries for health care. The price of a liver transplant in India, for example, is one-tenth the price of the same procedure in the United States (US).[15] India also attracts such 'health tourism' from neighbouring developing countries like Bangladesh.

Though statistics on cross-border supply (GATS Mode 1) are notoriously difficult to come by, there is no doubt that enhancements in technology are permitting increasing numbers of patients to consume cross-border health services from foreign professionals around the globe through various 'telehealth' applications, such as the remote diagnosis of a patient's condition by a physician outside the country evaluating X-rays and other information provided electronically.[16] As well, information technology is facilitating an explosion in the remote delivery of education and training across national borders.[17]

Also increasing in importance is the delivery of services through a commercial presence (GATS Mode 3). Foreign hospitals, clinics, and other treatment and long-term care facilities are permitted to enter markets in many developing countries like India, Indonesia, Nepal, Sri Lanka, and Thailand. Some education institutions have set up a commercial presence abroad to offer programmes either in the form of green-field investments or in partnership with local institutions in developing countries. The Massachusetts Institute of Technology for example has established a partnership with some Malaysian institutions to offer programmes in Malaysia. Such partnerships with prestigious foreign institutions are growing and their services may replace, to some extent, services consumed abroad.[18]

Finally, more and more individual health and education professionals from developing countries provide their services abroad each year (GATS Mode 4). This has been modestly facilitated in health services

[15] R. Chanda, 'Trade in Health Services' in 80 *Bulletin of the World Health Organization* (2002) 158.

[16] G. Wolvaardt, 'Opportunities and Challenges for Developing Countries in the Health Sector' in S. Zarrilli and C. Kinnon (eds), *International Trade in Health Services: A Development Perspective* (1998) at 63.

[17] Distance education represents 6 per cent of international student enrollment and has been growing steadily since 1996: K. Larsen and S. Vincent-Lancrin, 'International Trade in Education Services: Good or Bad?' in 14 *Higher Education and Management Policy* (2002).

[18] By 1996, 140,000 students were enrolled in foreign subsidiaries of British institutions of higher education outside the UK compared to 200,000 foreign students studying in the UK: Larsen and Vincent-Lancrin, *ibid*.

by a trend toward globalization of medical education and information, standards, and practice.[19] For both health and education the non-recognition in developed countries of domestic qualifications and experience acquired in developing countries as well as visa and immigration constraints continue to represent a significant impediment to the movement of developing country professionals abroad.

D. A taxonomy of possible effects of trade liberalization in health and education[20]

In this section, the costs and benefits of service trade liberalization are set out for each of the four modes of supply contemplated in GATS. This taxonomy suggests the nature and direction of trade effects but not their relative magnitude or the corresponding policy implications which are likely to be different for each developing country, depending on local conditions.

1. Mode 1: Cross-border supply

Cross-border supply typically involves the delivery of a service from a foreign location via the internet or some other kind of communications technology. From the perspective of a developing country considering the import of health and education services through this mode, a wide range of possible benefits, both economic and non-economic, may be identified. With respect to health, technologically mediated supply could mean better access to a wider range of services and treatments and better disease monitoring, especially in remote areas. Similarly in education, all manner of educational programmes could become accessible in this way enhancing student choices for developing country consumers. In areas in which conventional face-to-face education is limited or non-existent the potential gains in access may be enormous. Enhanced availability of education and health services and access to expertise in these areas especially in remote regions may also contribute to higher rates of local staff retention as well as reduced internal and foreign migration. Both would have a positive impact on the delivery of local services.

The main barrier to the delivery of services through this mode is the absence of the necessary telecommunications infrastructure and technology in many developing countries. Given the magnitude of the need for improved access to health and education services in developing

[19] D. Warner, 'The Globalization of Medical Care' in S. Zarrilli and C. Kinnon (eds), *International Trade in Health Services: A Development Perspective* (1998) at 71.

[20] See Chanda, *supra* n. 15, and Blouin, *supra* n. 11, for further discussion of the possible effects of trade liberalization in health services. Regarding education services see Larsen and Vincent-Lancrin, *supra* n. 17.

countries, the scarce state resources necessary to put such infrastructure and technology in place may be better spent on the direct provision of basic health and education services. Nevertheless, in terms of cost-effectiveness, it is possible that the use of technology may offer certain efficiencies. Technology may increase the productivity of health and education workers, for example. As well, the same technology may be used to support both education and health services delivery.

Apart from the cost of enabling technology, the main concern for governments associated with cross-border supply from abroad is how to ensure that foreign suppliers meet domestic quality standards.[21] Recognition of foreign qualifications in the areas of education and especially health remains limited. Imposing quality standards on health and education services suppliers who never physically enter the country poses additional challenges.

Export opportunities through the cross-border supply of health and education services may be non-existent or limited for many developing countries. Nevertheless, there may be areas in which opportunities exist. It may be cost-effective to locate back-office functions related to health and education services, like health insurance claims processing and medical record-keeping and transcription, in developing countries that offer lower labour costs and the availability of well-trained workers with appropriate linguistic and technological skills, such as India and the Philippines.[22] Where concerns of importing states regarding the qualifications of health and education professionals can be overcome, there may be some prospect for the cross-border export of services, particularly to other developing countries. In order to be able to take advantage of any such prospects, public investment in telecommunications infrastructure may be required. Again, the opportunity costs of such an investment, taking into account any offsetting efficiencies and other gains from trade, would have to be considered.

2. Mode 2: Consumption abroad

The import of health and education services through Mode 2 involves the citizens of a country going abroad for medical treatment or to

[21] For further discussion of the costs and benefits of 'telehealth', see S. Mandill, 'Telehealth: What is it? Will it Propel Cross-Border Trade in Health Services?' in S. Zarrilli and C. Kinnon (eds), *International Trade in Health Services: A Development Perspective* (1998) at 79. Regarding cross-border trade in education see S. Bjarnason, 'Debate on Education and GATS: Where Do We Stand?' in *Report of the 15th CCEM Preliminary Meeting on Education and the General Agreement on Trade in Services: What Does the Future Hold?* (May 2003).

[22] D. Lipson, 'GATS and Trade in Health Insurance Services: Background Note for the WHO Commission on Macroeconomics and Health' in *Working Paper for Commission on Macroeconomics and Health* (2001).

participate in education programmes. For a developing country, imports through Mode 2 may be a substitute for foreign services provided to the same domestic population though services suppliers who enter the local market through a commercial presence (Mode 3) or individually (Mode 4). Mode 2 imports involve certain costs. Most directly, domestic resources will be spent abroad. In education services, any negative effects will be offset to some extent if citizens who complete education abroad return to enhance the human capital of their home country. When high-achieving local students go abroad to study but never return, Mode 2 imports risk contributing to a loss of human capital or 'brain drain' from developing countries.

Since, inevitably, it will be the more affluent among a country's population who will be aware of and able to engage in consumption abroad, a less direct problem may be the development of a two-tier market, where the rich travel abroad for education and medical treatment while the poor must rely on inferior services available at home. Such a two-tier market may have some offsetting benefits to the extent that consumption abroad relieves pressures on the limited resources of domestic public health and education systems. At the same time, however, a two-tier market may weaken political support for public systems. If an influential segment of the population does not see its direct interests being served by public health and education services, its support for such services may erode.

The export of health and education services by a developing country through Mode 2 consists of foreign individuals coming to the country to consume these services. Particularly in health care this form of consumption abroad may be attractive to citizens in developed countries. The burgeoning numbers of retirees in developed countries with increasing health-care needs may lead to increased interest in cheaper care in developing countries, especially among those who have ethnic, cultural, or other ties. The comparatively low cost of high-quality services and access to alternative treatments may draw developed country consumers to developing country services. For a developing country, such 'health tourism' would be a source of foreign exchange and domestic employment. The prospect of serving a richer foreign clientele may encourage local investment and foreign investment (trade in services through Mode 3) in new health and education facilities and the provision of a wider range of higher-quality services. In education, there may be cultural benefits in having foreign students studying domestically. In developing country markets that are geographically close to major developed countries, like Mexico and Morocco, the potential for gains from Mode 2 exports would likely be greatest. At the same time, improved local services will tend to discourage locals from

engaging in consumption abroad (Mode 2 imports), mitigating the costs associated with Mode 2 imports described above. Improved opportunities for local health and education professionals may reduce incentives for them to emigrate.

Exporting health and education services through Mode 2 would have little impact on improved provision to the poor, unless some of the returns to local suppliers could be recovered by the state through taxes, and government receipts were used to fund services to poorer segments of the population. This is because investment in health and education facilities to provide services to foreign clients will be most attractive in the most lucrative services. Such 'cream-skimming' leaves the expensive remainder of services to be supplied by the state.[23] There may be other disadvantages associated with local investment in private health and education services catering to affluent foreign consumers, such as contributing to the development of a two-tier local market for these services. Well-off local consumers may abandon public services in favour of new private services. While this may relieve pressure on public services, in such a two-tier market there may be an internal brain drain as local health and education professionals migrate from public-sector to private-sector suppliers. Finally, to the extent that the two-tier market becomes entrenched, political support for public services may be undermined.

These possible threats to equity and access must be viewed in the appropriate context. Existing public systems of health and education services in developing countries are far from perfect. Some existing public systems already serve the rich disproportionately or, as a result of corruption and inefficiency, are substantially impaired in terms of achieving their social and development objectives.

Also, as discussed in more detail in the following sections, some negative side-effects may be managed if not eliminated by appropriate domestic regulation. GATS does not preclude governments from adopting measures to address internal brain drain by discouraging the movement of health and education professionals from the public to the private sector. Equally no provision in GATS restricts measures by governments relating to foreign patients. Even if full commitments were undertaken in hospital services, for example, GATS would permit a Member to tax the fees paid by foreign patients.[24] The feasibility of

[23] In health, for example, private investors may only be interested in providing a limited range of services at high prices to wealthy patients, leaving the state to deliver complex and expensive treatments to indigent patients.

[24] R. Adlung and A. Carzaniga, 'Trade in Health Services Under GATS' in 79 *Bulletin of the World Health Organization* (2001) 352. The authors have produced an updated version of their paper dated June 2003.

imposing regulatory solutions such as these in a particular state will depend on an appreciation by the government of the potential problems and the presence of the political will to address them, as well as on the state's regulatory capacity to implement these kinds of measures to complement its liberalization initiatives. In many developing countries, a chronic lack of capacity to regulate private suppliers may impair the prospects for effectively ensuring that the public interest is served and progress toward development objectives is achieved where private supply is permitted.

3. Mode 3: Commercial presence

As noted above, foreign investment in health and education services would result in the inflow of capital, expansion of employment, and, possibly, the provision of new and improved services. The efficiency and quality of services may be enhanced through the introduction by foreign investors of new technologies in developing countries. Local expertise may be enhanced through opportunities to work with these technologies at facilities established or expanded through foreign investment. In the area of health, at least, the available empirical evidence does not consistently show improvements in cost-effectiveness and service quality associated with the supply of health services by private suppliers, domestic or foreign.[25] Perhaps a more certain benefit from the augmentation of local services through foreign direct investment is that resources for the public-sector would be freed up as a result of reduced demand for public-sector services.

The development of high-quality private facilities through foreign direct investment may have an effect on trade in other modes. Improved local services through foreign investment may reduce reliance on consumption abroad (reducing Mode 2 imports) for the segment of the population for whom that is an alternative and stem the associated loss of foreign exchange. At the same time, such services may enhance opportunities to attract foreign consumers, contributing to Mode 2 exports. Opportunities to work in foreign-owned facilities may reduce the pressure for professionals to emigrate, curtailing trade through the presence of natural persons abroad, reducing exports in Mode 4.

Possible negative effects may also be identified. Most obviously, foreign investment would lead to an outflow of profits to foreign owners. As well, there may be a significant opportunity cost associated with the public investment that may be required in order to attract private investment in developing countries. Foreign investors may crowd out local suppliers. Given the serious and chronic shortages in

[25] Blouin, *supra* n. 11.

health care and many education services in most developing countries, however, crowding may not be a serious problem in many cases. The presence of foreign private services suppliers may also contribute to the development of two-tier markets for health and education services. Investment may not flow to where it is most needed from a health and education policy point of view. As noted above, foreign investors are likely to try to cream-skim the most lucrative services leaving the remainder of services to the state and local firms. To the extent that new private firms siphon off workers from public sector and local private sector suppliers foreign investment could contribute to an internal brain drain.[26] Finally, if a two-tier market becomes entrenched, there may be a political cost to the extent that some local consumers no longer see their interests as being served by publicly funded services.

Again, the significance of these possible negative effects will depend on the domestic context. For example, the cost of any public investment necessary to attract foreign direct investment will depend on the degree to which factors encouraging such investment are already present, including local market size. As well, one must ask how the results of a liberalized system would compare with the existing public systems of health and education. It may be possible to address some of the negative effects by GATS consistent domestic policies. The development of cream-skimming and a two-tier market, for example, could be avoided by the imposition of requirements for foreign services suppliers to locate in underserved areas combined with obligations to provide an identified range of services to all citizens at government specified rates. In health care, less intrusive regulation could require a specific number of hospital beds to be set aside for low-income patients at prescribed rates. Similarly, places in schools set up with the assistance of foreign investors could be reserved for disadvantaged segments of the population. The internal brain-drain problem could be mitigated if requirements to train local staff were imposed on foreign investors or measures were adopted to make moving to the private sector unattractive.

The GATS preamble contains a general recognition of the right of WTO Members to regulate and no provision in GATS precludes these kinds of measures. Where a Member has listed a health or education service in its national schedule of commitments, however, the Member's freedom to impose some of these kinds of policies would require that they be covered by a limitation on the Member's obligations. In order to preserve the Member's freedom to limit the number of suppliers in

[26] Apparently this occurred in connection with reforms to permit foreign investment in hospitals in Thailand: Chanda, *supra* n. 15.

a particular area, for example, a limitation on the Member's market-access obligation to this effect would be required.

While foreign direct investment originating in developing countries may not be substantial, it does occur in the health and education sectors. For example, one Indian hospital group is seeking to build hospitals in Malaysia, Nepal, and Sri Lanka.[27] The main benefit of these kinds of investments is that they may generate financial benefits in terms of profits repatriated.

4. Mode 4: Presence of natural persons

The movement of health and education professionals from developing countries to provide services abroad has a variety of both costs and benefits. Significantly, developing country professionals working abroad generate remittances to their country of origin. Working in another country may allow professionals to acquire new knowledge and skills which may be employed usefully on their return home.

As against these benefits there are also costs. Providing services abroad results in a reduction in the human resources available for delivery of health and education services in developing countries. The significance of this effect will be highly variable. For some professions in some countries movement abroad will cause or exacerbate local shortages, sometimes severely. In other cases, local surpluses may exist. As well, it may be feasible and cost-effective for some countries to import professionals to replace locally trained professionals who move abroad. Jamaican nurses, for example, commonly move abroad to provide services in the US and Canada and are replaced, to some extent, in Jamaica by nurses from Nigeria, Ghana, and Myanmar.[28] The net effect, however, has been serious shortage of nurses in Jamaica.

Where stays abroad become permanent the movement of health and education professionals becomes a brain drain with the attendant loss of public investment in the education of departed professionals. There is also the question of the distributive impact of remittances which are received by private rather than public hands. While there will be dispersed economic benefits to the use of remitted funds in the local economy, remittances are not directly available to the state to be applied to ensure the achievement of public policy goals.

Again, there are a variety of GATS consistent regulatory measures that may be adopted to counteract possible negative effects associated with increased export trade in Mode 4. Public investment in education

[27] Chanda, *supra* n. 15.
[28] WTO Secretariat Note on Health and Social Services, *supra* n. 5.

and training can be safeguarded by requirements to work locally for a period of time upon completion of education and training programmes. India and South Africa impose such requirements. Alternatively, departing professionals could be required to post a bond recoverable upon their return.

The likely effect of migration of health and education professionals to developing countries has been and will continue to be less significant than migration in the other direction. Nevertheless, to the extent that foreign health and education professionals from developed countries may work in developing countries local shortages in particular areas may be overcome. Migration from one developing country to another to address local shortages may be a more common occurrence, as illustrated by the Jamaican nursing example cited above.

III. A PROFILE OF CURRENT GATS OBLIGATIONS: LOW LEVELS OF SPECIFIC COMMITMENTS[29]

A. Introduction

In this section the specific commitments undertaken by WTO Members in health and education services under GATS are discussed. By specifically listing a services sector in its national schedule of commitments, each WTO Member commits to complying with a higher level of obligation under GATS including providing national treatment and not imposing certain restrictions on market access. The level of obligation may be reduced by limitations inscribed by the Member in its national schedule. Even in the absence of specific commitments, health and education services are subject to the limited general disciplines of the GATS, including transparency and the MFN obligation, unless they are excluded as services supplied 'in the exercise of governmental authority'.

B. Health

Along with education, health services are among the least committed services sectors. Only 42 per cent of Members have undertaken

[29] The commitments of WTO Members in health and related services are described in more detail in Adlung and Carzaniga, *supra* n. 24. The commitments of countries in education services are summarized in OECD, *CERI Background Document: Current Commitments under the GATS in Education Services* (2002) prepared for the OECD/US Forum on Trade in Education, held in Washington, DC in June 2002.

any specific commitment in relation to a health service.[30] Overall, commitments tend to be positively related to the level of development—only about one-third of the 100 developing and least developed country Members[31] have made commitments in health—though there are some significant exceptions. Botswana, Burundi, the Gambia, Lesotho, Malawi, Sierra Leone, and Zambia, all least-developed countries, undertook commitments in at least one health sector. All but one[32] of the developing countries that have joined the WTO since 1995 have accepted some commitments in health services reflecting the greater negotiating pressure to make commitments experienced by such countries in relation to all services sectors. As well, some developed countries, like Canada, have accepted no obligations in health services. Commitments by the US and Japan are limited to hospital services.

For WTO Members that have made commitments, most have been in medical and dental services (50 of 146 or 34 per cent of all Members) followed by hospital services (41 of 146 or 28 per cent of all Members), 'other health services' (23 of 146 or 16 per cent of all Members), and the services of nurses and other health professionals (21 of 146 or 14 per cent of all Members). Commitments by developing countries follow this same pattern, though the percentage of developing countries making commitments was lower in each category of health services (25 per cent for medical and dental services, 23 per cent for hospital services, 10 per cent for other health services, and 7 per cent for the services of nurses and other health professionals). This pattern suggests that more WTO Members were willing to make commitments in capital-intensive services like hospitals and highly specialized services like those of physicians and dentists as compared to more labour-intensive services, like nursing.[33]

The precise content of Members' commitments varies to some extent based on the express wording of the commitment. Typically, the open-ended category of 'other health services' was left undefined, but a few countries provided their own definitions for the purposes of their commitments. Australia listed only chiropody and podiatry in this category and Belize accepted commitments for epidemiological

[30] All statistics in this section were calculated as of 1 January 2004 and so do not include the commitments of Nepal which became a WTO Member in April 2004. Also the statistics are based on the 12 countries that were members of the European Community prior to 1995 constituting one Member. Health insurance is not discussed, though the availability of private health insurance will have implications for access to health services. See Lipson, *supra* n. 22.

[31] For the purposes of this paper, statistics referring to developing countries include least-developed countries. All transition economies have been removed from the category of developing countries except China and Mongolia.

[32] The sole exception is Mongolia.

[33] Adlung, *supra* n. 1.

services and some diagnostic services. Some Members restricted their commitments to granting market access for private hospitals.

In terms of modes of supply, WTO Members making commitments in health services imposed the fewest limitations on their obligations in Mode 2, probably reflecting the view that restrictions on this mode of supply would not be effective, even if they were desirable for some reason. A higher percentage of developing countries made full commitments for Mode 2 trade in health services (except for other health services) compared to the percentage of all WTO Members. A full commitment means that a Member imposed no limit on either the national treatment or market access obligation. Of those Members listing limitations on their obligations in Mode 2 most related to restrictions on the portability of health insurance or horizontal limitations relating to subsidies. These limitations preserve Members' flexibility to refuse to subsidize or reimburse patients for payments made for foreign medical services consumed outside the country.

The relative openness of large developed and developing country markets in Mode 2, including the European Communities for all health services, China for medical and dental services, and the US and Japan for hospital services, suggests a market opportunity for services suppliers from developing countries providing cost-effective or unique health services to attract foreign consumers from those states. Limitations on the availability of public funding to patients who travel abroad would curtail this opportunity somewhat.

Roughly half the WTO Members accepting commitments in health services sectors made full commitments in Mode 1. For all health services, a higher percentage of the developing country Members accepting commitments undertook full commitments. Most Members that did not accept full commitments to provide national treatment and market access for Mode 1 simply recorded their commitments as 'unbound', meaning that no commitment at all was accepted by the Member for that mode. Some of the unbound listings were due to the belief that the delivery of these services was technically unfeasible. Others may reflect uncertainty regarding the scope of the commitment given the fast-evolving nature of electronic delivery of services or concerns about how to regulate service quality. In one of the few specific limitations that cut back Member's obligations in Mode 1, Poland's schedule provides that public insurance need not cover medical care supplied through Mode 1.

Aside from the category of other health services, less than half of WTO Members making commitments in health services gave a full commitment for supply of health services through a commercial presence (Mode 3), though again the percentage of developing countries

giving full commitments was higher, especially in relation to the services of nurses and other health professionals. Few Members, however, recorded the Mode 3 commitments as unbound. Many limitations imposed by Members on their obligations in Mode 3 consist of horizontal limitations relating to all services sectors that allow Members to restrict the percentage of permissible foreign ownership or the type of legal form that foreign services suppliers may employ for the purposes of their commercial presence or to require approval of foreign investments. In some cases, countries preserved their ability to impose a requirement for the satisfaction of an economic-needs test before the establishment of a commercial presence would be permitted. Often no specific criteria for the application of the test were set out, contrary to the WTO's scheduling guidelines, leaving a wide discretion to governments regarding its application. Such discretion would permit a Member to impose limits on the number of operations in specific locations and other limitations which are measures that could be used to address some of the possible negative effects of liberalization noted in the taxonomy of possible trade effects but which would otherwise be contrary to the market access obligation. In some cases, requirements for economic-needs tests were included in sector specific commitments for medical, dental, and hospital services. Of developing countries, only Malaysia included such a limitation and only in relation to its commitments for hospital services.

Almost all Members accepting commitments in health services, including most developing country Members, imposed significant limitations on their obligations to permit the presence of natural persons supplying health services (Mode 4). Some Members set out specific limitations on their obligations, but more than 75 per cent described their obligations as 'unbound' for all health services sectors. Limitations specifically applicable to Mode 4 obligations found in Member's schedules consist of quotas and specific training and language requirements. In many cases, Members who listed their obligations as unbound indicated that their obligations were nevertheless subject to their horizontal commitments. Many of these countries undertook to grant Mode 4 access to certain intra-corporate transferees. Typically these commitments relate to certain kinds of persons who work for a foreign business that has operations in a Member's country and who are permitted to enter the country on a temporary basis to work at the business's local operations. Such a commitment in Mode 4 means that access for individuals is conditional on the establishment of a commercial presence. This kind of access is likely to be of marginal value to developing countries who are not engaged in significant outward foreign direct investment, though as noted above, there are

some exceptions in this regard. In some cases, Members listed horizontal obligations to provide access that are restricted to a small range of specialists, though often only if labour-market tests are satisfied. The magnitude of restrictions on Mode 4 reflect the political sensitivity of access to the local labour market.

C. Education

Approximately 30 per cent of Members have undertaken a specific commitment in some education sector (44 of 146 Members). Twenty-five out of 30 OECD countries have made a commitment in at least one education sub-sector.[34] For the 100 developing country Members, the percentage taking on commitments was only 17 per cent. As with health services, developing countries that became WTO Members after the Uruguay Round have committed to a higher level of obligation in a wider range of education sectors than the countries that made commitments at the conclusion of the Uruguay Round.

For Members making commitments, all education sectors were the subject of a similar number of commitments: 30 for primary education, 34 for secondary education, 33 for higher education, and 32 for adult education. Only 20 Members made commitments for other education, most leaving this category undefined. In general, WTO Members have put more limitations on their obligations relating to trade in primary and secondary education than on those relating to higher and adult education. Adult education is the sector in which countries have made most full commitments in Modes 1 to 3.

In defining the scope of their commitments in education many Members deviated from the WTO's Classification List and the more detailed Provisional CPC. In primary education, 12 of 30 Members restricted their commitments to a distinctive category of services. Eight of these Members limited their commitments to private education. In secondary education, 16 of 33 Members adopted distinctions not present in the Classification List or the Provisional CPC. Again, most of these restricted commitments to private education. In higher education, 15 of 33 countries adopted their own categories, 10 limiting their commitments to private education. The only developing country to limit its commitments to privately funded education was Mexico. China, however, may have achieved a similar result by excluding national compulsory education from its commitments in primary and secondary education.

[34] The five OECD countries that have not made commitments in education services are Canada, Finland, Iceland, Korea, and Sweden.

In terms of modes of supply, all WTO Members accepting commitments in an education sector committed to a high degree of freedom with respect to the consumption by their citizens of education services abroad (Mode 2). Over 85 per cent of Members accepting a commitment in an education services sector gave a full commitment for trade in services in this mode. Few countries either listed their commitments as unbound or inscribed some specific limitation on their obligations. Specific limitations in some countries schedules relating to Mode 2 allow them to restrict the availability of scholarships for education services provided abroad or to non-nationals. The pattern of commitments for developing country Members is essentially the same as for all Members making commitments.

A high percentage of WTO Members that accepted commitments in education sectors gave full commitments for Mode 1, though the percentages were lower for primary and secondary education than for other education sectors. The pattern of commitments for developing countries who accepted commitments in Mode 1 was the same as for other countries, though a higher percentage recorded their commitments as 'unbound', perhaps reflecting the relatively greater challenge of drafting satisfactory limitations for developing countries. A few Members' schedules allow them to restrict the availability of scholarships for education services provided abroad or to non-nationals.

As with health services, less than one-half of countries accepting commitments in most sectors of education services gave full commitments with respect to Mode 3, commercial presence. The only exception in this regard was adult education which attracted a full commitment from just less than 60 per cent of countries accepting commitments. On the other hand, fewer than 10 per cent of countries accepted no commitments at all in the education sectors listed in their national schedules for Mode 3. All countries recording their commitments as 'unbound' are developing countries.

National schedules thus demonstrate a relatively low commitment to giving full market access and national treatment for education services suppliers operating through a commercial presence, even for those WTO Members undertaking commitments, but a willingness to accept commercial presence with specific or horizontal limitations. The horizontal limitations referred to in relation to health services delivered in Mode 3 and discussed above apply as well to education services supplied in this mode. Few of these limitations appear to be targeted directly at the kinds of measures suggested in the taxonomy of possible effects of trade liberalization as being useful to counteract the negative effects of foreign investment in education services, such as

limiting the number of suppliers permitted to serve a particular area, though some broad horizontal limitations may preserve this flexibility. There is little difference in this regard between the commitments of developing countries and other WTO Members.

As with health services, Mode 4 received the lowest level of commitments in education services. Only one country gave a full commitment in any education sector for this mode. Most of the countries that recorded their obligations as 'unbound' referred to their horizontal commitments. In many of these horizontal commitments, Members have provided a limited undertaking to provide market access for some intra-corporate transferees and some specialist professionals that, as indicated previously, will be of limited value to most developing countries. The pattern of commitments for developing country Members is essentially the same as for all Members.

IV. GATS NEGOTIATIONS TO DATE: HEALTH AND EDUCATION ON THE BACK BURNER

There is no sector, including health and education, that is *a priori* excluded from the current round of negotiations. As well, strong export interests exist in some countries in these services. With respect to education, Australia, Canada, New Zealand, the UK and the US are all significant exporters.[35] In health services, the US and many other developed countries as well as a few developing countries have export interests.

Despite these interests, health and education have not been significant subjects of discussion in the current round of negotiations. Health was not the subject of any specific negotiating proposal. Four countries, Australia,[36] Japan,[37] New Zealand,[38] and the US[39] have filed negotiating proposals related to education but none could be characterized as suggesting an aggressive approach to liberalizing trade in education

[35] Larsen and Vincent-Lancrin, *supra* n. 17. For example, in 2000, education exports represented 11.8 per cent of Australia's total services exports and ranked as the third largest category of services exports and the 14th largest category of all exports.

[36] *Communication from Australia: Negotiating Proposal for Education Services*, 2001 (S/CSS/W/110).

[37] *Communication from Japan: Negotiating Proposal on Education Services*, 2002 (S/CSS/W/137).

[38] *Communication from New Zealand: Negotiating Proposal for Education Services*, 2001 (S/CSS/W/93).

[39] *Communication from the United States: Higher (Tertiary) Education, Adult Education, and Training*, 2000 (S/CSS/W/23).

services. Each expressly recognizes the important role played by the state in funding, delivering, and regulating education as well as the important link between education and social and economic development. As well, each is limited in its scope. The US proposal only relates to higher and adult education and training by private operators. New Zealand's is largely restricted to some suggestions for clarifications regarding the categories of education services used to schedule specific commitments. The main emphasis in Japan's proposal is the need to maintain quality in education, especially education services supplied cross-border. Australia's communication identifies possible benefits associated with more liberal trade in education services as well as some of the barriers currently impeding trade but the proposal itself is restricted to five principles that are relevant to liberalization initiatives, most of which focus on the maintenance of state sovereignty in this area.

The requests and offers of WTO Members that have been filed with the WTO are confidential. A review of those requests and offers that have been made public to date, however, reveals few that deal with health or education services. With a couple of modest exceptions, the market-access offers that have been made public do not contain improved commitments specifically relating to health or education.[40] Similarly, while the fragmentary nature of the available public information precludes anything like a complete picture, it also appears that few requests have been made for improved market access in health and education services.

All of the EU's requests are publicly available and only two relate to health or education. The EU has asked the US for improved access for private suppliers in the higher education sector and asked the Dominican Republic to drop its MFN exemption for medical, dental, and nursing services.[41]

India has provided comprehensive information on the requests that it has made and received though has not identified the recipient of its requests or the countries from which requests have been

[40] Offers from the following have been made public and can be found on the WTO website in the TN/S/O document series: Australia, Canada, Chile, EU, Iceland, Japan, Liechtenstein, New Zealand, Norway, Slovenia, Turkey, and the US, online at http://www.wto.org/english/tratop_e/serv_e/s_negs_e.htm. Japan has offered some improvements in its commitments regarding Mode 2 trade in higher education services and the US and the EU have offered slight improvements in their commitments in higher education services.

[41] The complete text of the EU's requests has been posted on the internet by the non-governmental organization GATSwatch, online at http://www.gatswatch.org/requests-offers.html. The EU itself has provided a summary of its requests (Summary of the EC's Initial Requests to Third Countries in the GATS Negotiations (1 July 2002), online at http://europa.eu.int/comm/trade/services/gats_sum.htm).

received.[42] In relation to health services, India currently has a commitment only in hospital services. It has received requests for full market access for medical and dental services, and the services of nurses and other health professionals in Modes 1, 2, and 3 as well as some commitments to permit foreign health professionals to operate in India through Mode 4. With respect to hospital services, India has received requests for full commitments in Modes 2 and 4, as well as the removal of its 51 per cent equity limit on foreign investment in hospitals. For its part, India has made requests for full commitments in health professionals in Modes 2 and 4, including the removal of residency and nationality commitments and, with respect to Mode 4, commitments to permit access for health professionals unrelated to businesses operating in Mode 3. As additional commitments, India has requested recognition for the qualifications of Indian medical and dental professionals and nurses.

In education services, India currently has no commitments and has been asked to provide full commitments for higher education, adult education, and other education, including educational testing, community education, and education agency services in Modes 1, 2, and 3. India has requested as additional commitments more transparent mechanisms for the accreditation of courses and programmes provided by education service suppliers, including an appeal process with respect to accreditation decisions.

Australia has made public its request for improved market access for private hospital and private care for the aged services. Australia has not identified the recipient(s) of its request.[43] Other publicly available information disclosed no other requests relating to health or education.

In summary, while both health and education have been the subject of some requests, there is little to indicate that these services have been accorded a high priority in the negotiations by WTO Members.[44] One possible exception is Australia which has described its interest in improved market access for its suppliers of private hospital and care for the aged services as a negotiating priority. Also, India has expressed

[42] Government of India, Ministry of Commerce and Industry, Department of Commerce, Trade Policy Division, *Consultation Document on the WTO Negotiations Under the General Agreement on Trade in Services (GATS)*, online at http://commerce.nic.in/wto_counsel_paper.htm.

[43] 'Australia Pushes Export Opportunities for Tourism, Healthcare Businesses', *Media Release* (29 October 2002), online at http://www.trademinister.gov.au/releases/-2002/mvt139_02.html.

[44] 'Director-General of WTO and Chairman of WTO Services Negotiations Reject Misguided Claims that Public Services Are under Threat' *WTO Press Release/299* (28 June 2002).

a significant interest in greater mobility for its medical and other health professionals.

V. WHY SO LITTLE INTEREST IN GATS COMMITMENTS IN HEALTH AND EDUCATION?

A. Introduction

The taxonomy of possible effects of trade liberalization set out above shows that there may be benefits arising from liberalization of trade in health and education services. There are likely to be costs as well, though appropriate policies complementing liberalization initiatives can address at least some of the possible negative consequences in a manner consistent with GATS. Nevertheless, so far relatively few countries have made specific commitments in these services and publicly available evidence does not show a strong interest in additional commitments in the current round of negotiations. Why is this?

A variety of possible explanations may be suggested. The most straightforward reason for the low level of existing commitments may be simply that, in some cases at least, no one asked developing country Members for commitments in these sectors during the Uruguay Round. These sectors were not high on negotiators' lists of priorities. As well, in countries in which health and education services are largely supplied through government monopolies, it might have been thought that there was no point in undertaking commitments. It has also been suggested that the commitments in health and education were impeded by a low level of familiarity with GATS among health and education officials and inadequate dialogue between them and trade officials.[45]

The reason most frequently cited for avoiding commitments in health and education services in the current negotiations, however, is uncertainty regarding the nature and effect of GATS commitments. The three main categories of uncertainty may be identified as uncertainty regarding:

- the scope and nature of GATS obligations;
- the trade impact of GATS commitments;
- the likelihood that governments may need or want to adopt future policies in health and education that may be inconsistent with specific commitments in GATS.

[45] OECD Observer, *supra* n. 10.

B. The three uncertainties of GATS

1. Uncertainty regarding the scope and nature of GATS obligations

When GATS came into force on 1 January 1995, it was the first set of comprehensive multilateral rules dealing with trade in services. Many provisions in the agreement are novel, including the application to services of concepts like MFN and national treatment that are well known in trade agreements relating to goods but new in the area of services. The scope and nature of GATS is only beginning to be fleshed out in WTO dispute settlement proceedings.

Many commentators and even the WTO Secretariat have expressed some concerns regarding the precise scope of the services agreement because of uncertainty regarding the carve-out for 'services supplied in the exercise of governmental authority'.[46] This expression is defined to mean 'any service that is supplied neither on a commercial basis nor in competition with one or more service suppliers'. The application of the criteria in this definition to health and education services is not straightforward because in many countries private and public providers of health and education coexist and public provision may be implemented through private-sector suppliers. As a result, some aspects of national public health and education systems may be subject to the agreement. For example, if universally available publicly funded health services provided free to consumers were supplied by hospitals or physicians that are organized on a for-profit basis, it could be that such services are provided on a commercial basis and are thus outside the exclusion and subject to the GATS. Some have worried that even if services are delivered directly by the state, such as public schools, the mere existence of private schools seeking to serve the same students means that the exclusion has no application because the public and private schools will be found to be in competition and the services of public schools would then be subject to the agreement.[47]

In response, it must be said that some level of uncertainty is the inevitable consequence of applying a short, broadly worded treaty provision, like the exclusion for services supplied in the exercise of governmental authority, to services that are the subject of a range of complex regulations and methods of delivery like health and education.

[46] E.g. M. Krajewski, 'Public Services and Trade Liberalization: Mapping the Legal Framework' in *Journal of International Economic Law* (2003) 341; WTO, Council for Trade in Services, Environmental Services: Background Note by the Secretariat (1998) (S/C/W/46) at 14, 15; WTO, Council for Trade in Services, Education Services: Background Note by the Secretariat (1998) (S/C/W/49) at 4–6.

[47] Among the most prominent critical analyses are S. Sinclair, *GATS: How the World Trade Organization's New 'Services' Negotiations Threaten Democracy* (2000); and J. Grieshaber-Otto and S. Sinclair, *Facing the Facts: A Guide to the GATS Debate* (2002).

As well, the exclusion is likely to be interpreted more generously than the critics fear. The simple coexistence of public and private services should not lead to the conclusion that public services are in competition.[48] Nevertheless, the inability of governments in WTO Member states to define precisely which aspects of national health and education systems are subject to the agreement and which are not has made it difficult to reassure domestic interests that public services are not threatened in any way by GATS and has impeded the progress of domestic discussions regarding how GATS obligations could be helpful in promoting better outcomes in health and education.

This is unfortunate because the application of this exclusion should not be the key concern of policy-makers or those with a stake in health and education. So long as a government has not taken the additional step of accepting specific commitments for health or education services, the remaining GATS obligations that do apply are unlikely to impose meaningful constraints on governments.[49] The main substantive obligation is MFN treatment which does not require providing any degree of access for foreigners to domestic markets.

Uncertainty regarding the scope of the substantive obligations in the GATS that become applicable when specific commitments are undertaken has also been raised as a concern. The national treatment obligation only requires that foreign service suppliers and services be treated no less favourably than like domestic service suppliers and services. Because it is necessary to make an assessment of the likeness of service suppliers or services, the precise impact of this obligation will depend on the facts of each case. In determining the likeness of goods, WTO panels have focused on the attributes of the products and whether they are competitive substitutes in the market. It remains to be seen whether services that are substitutes in this sense may nevertheless be found not to be like for the purposes of the national treatment obligation on other grounds. It is not clear, for example, whether foreign services that are treated differently from domestic services in order to achieve legitimate regulatory objectives, such as consumer protection, should not be considered like services and therefore not protected from such discrimination by the national treatment obligation.[50] Where the national treatment obligation applies, it is

[48] J. A. VanDuzer, 'Health, Education and Social Services in Canada: The Impact of the GATS' in *Trade Policy Research* (2004) 303.

[49] D. Luff, 'Regulation of Health Services and International Trade Law' in A. Matoo and P. Sauvé (eds), *Domestic Regulation and Services Trade Liberalization* (2003) 191.

[50] As an example of the kind of uncertainty that could arise in the services context, imagine an Indian medical laboratory that does diagnostic work for patients in India and a British laboratory that performs the same diagnostic work for the same Indian patients over the internet from its location in the UK. Because of its remote location, it may be

not yet clear what differences in treatment will result in less favourable treatment contrary to the obligation.[51] In the few cases dealing with the GATS to date, WTO panels have provided little guidance on these issues. As a result, the effective scope of the national treatment obligation under the GATS is much less certain than the analogous obligation for goods under the GATT, discouraging the making of commitments.[52]

Perhaps the most important area of concern regarding the scope of the substantive obligations in GATS is the application of GATS disciplines on domestic regulation. The preamble of the GATS expressly acknowledges the 'right of Members to regulate' as well as the need to give 'respect to national policy objectives' and the 'particular need for developing countries to exercise this right'. These preambular statements provide an important part of the interpretive context for understanding the substantive standards of the agreement, but are not substantive rules in themselves. With respect to the substantive rules on domestic regulation, the GATS requires that measures relating to qualification requirements and procedures, technical standards, and licensing requirements not nullify or impair a Member's specific commitments in listed sectors by imposing requirements or standards not based on objective and transparent criteria, such as competence

harder for Indian regulators to detect and impose sanctions for non-compliance with quality standards on the British laboratory. The Indian government may want to impose additional regulatory requirements on a foreign-based laboratory to ensure the protection of Indian consumers and the achievement of other regulatory objectives. These might include more onerous reporting requirements or requiring a cash deposit to ensure that any fine imposed to sanction non-compliance would be paid. Consistent with the national treatment obligation, what scope is there to impose these kinds of different regulatory requirements on the British laboratory? For there to be a breach of national treatment, these two service suppliers (or their services) must be found to be like and any difference in treatment must be such as to impair the competitive opportunities in the Indian market for the British laboratory as compared to the Indian laboratory. The scope of the national treatment obligation and the corresponding freedom to treat foreign suppliers differently in these sorts of situations is not clear.

[51] G. Verhoosel, *National Treatment and WTO Dispute Settlement: Adjudicating the Boundaries of Regulatory Autonomy* (2002) at 14–18. These same issues arise with respect to MFN. Abu-Akeel concludes that these issues in the MFN context are difficult and not capable of being resolved by WTO dispute settlement panels. He argues that the Council on Trade in Services should issue guidelines to address these issues: A. K. Abu-Akeel, 'The MFN as it applies to Service Trade: New Problems for an Old Concept' in 33 *Journal of World Trade* (1999) 103, at 115. Matoo suggests that the MFN obligation should only be breached when differences in treatment cannot be justified as necessary to achieve a legitimate non-discriminatory policy objective: A. Matoo, 'MFN and GATS' in T. Cottier and P. Mavroidis (eds), *Regulatory Barriers and the Principle of Non-Discrimination in World Trade Law* (2000) at 77–79.

[52] Some of the difficulties associated with interpreting the national treatment obligation are discussed in J. Trachtman, 'Negotiations on Domestic Regulation and Trade in Services: (GATS Article VI): A Legal Analysis of Selected Issues' in this volume.

and ability to provide the service, or that are more burdensome than necessary to ensure the quality of the service. These vague requirements are hard to apply in the context of health and education services where a variety of goals other than quality of the service, narrowly conceived, are fundamental determinants of public policy. It is not clear to what extent a measure related to, for example, imposing a new universal service obligation as a condition of being permitted to offer hospital services would be considered to relate to the quality of the service. If the measure was found to relate to quality, one may still wonder whether a new universal service obligation would be considered no more burdensome than necessary to ensure the quality of the service.[53] Alternative ways of ensuring the availability of hospital services to the population, such as through the use of some form of incentive, are certainly conceivable. Perhaps one could make arguments regarding the consistency of new universal service obligations and other measures common in the health and education sectors with the domestic regulation requirements. Nevertheless, uncertainty regarding the application of these requirements will discourage listing health and education services and becoming subject to GATS domestic regulation obligations as a result.[54]

Members' decisions regarding what to commit under the GATS have been made more difficult by the unrefined and imprecise categories of education and health services in the WTO's Sectoral Services Classification List and the corresponding divisions under the UN Provisional Central Product Classification. The distinctive architecture of GATS requires each Member to define the category of services activity in which it is willing to accept commitments. In both health and especially education, the Classification List and the Provisional CPC have proven to be inadequate models for countries seeking to make commitments. This is amply demonstrated by the fact that almost half of Members making commitments in education have used different categories of their own invention in their schedules and by the concerns and suggestions regarding education services classifications from two of the countries who have thought most about commitments in education—the US and New Zealand—both of whom focused on classification problems in their proposals for negotiations on education services. The content of 'other education services' in particular requires some further specification. In health as well, concerns have been expressed by WTO Members about the adequacy of the categories for

[53] This example is taken from Luff, *supra* n. 49 at 204–206.

[54] A much more comprehensive analysis of the challenges associated with interpreting the domestic regulation obligations is provided in Trachtman, *supra* n. 52.

scheduling services.[55] A simple issue, but one which arises under virtually every national health system, is whether services performed by physicians in a hospital, like most surgery, are hospital services or medical services.[56] While nothing prevents a Member from attempting to resolve these uncertainties by adopting its own classification system and nomenclature, the development and adoption of a single more specific and refined classification system would facilitate scheduling of commitments in a consistent manner and contribute to a common understanding among WTO Members regarding the nature of obligations undertaken.

2. Uncertainty regarding the trade impact of GATS commitments

GATS proponents advocate commitments in health and education that guarantee improved market access for foreign suppliers on the basis that such commitments will promote trade and investment leading to efficiency gains, increased consumer choice, reduced prices, innovation, and technology transfer. The taxonomy of possible effects of trade liberalization set out above describes the process by which such beneficial effects may occur. By creating binding commitments, GATS imposes disciplines on domestic policy-makers who may be tempted retreat from liberalization to engage in renewed protectionism as well as contributing to the transparency and predictability of domestic regulatory regimes. This is true even if GATS specific commitments simply confirm the status quo, as is the case in many national schedules. The enhanced predictability of a domestic regime bound by GATS commitments should encourage foreign businesses to participate in the market, especially through foreign direct investment.

But it is not clear how much of an effect GATS actually has in terms of increasing trade and investment, much less on the broader development outcomes critical to shaping health and education policy. To date, there is no empirical evidence demonstrating strong linkages between GATS commitments and increased trade or investment.[57]

This does not necessarily mean that GATS has not had any effect or that it could not have effects in the future. Nevertheless, in the areas of health and education, its impact will be restricted by the

[55] *Communication from the United States, Health and Social Services*, S/C/W/56 (1998).

[56] Luff, *supra* n. 49 at 198.

[57] WHO and WTO, *WTO Agreements and Public Health: A Joint Study by the WHO and WTO Secretariats* (2002) at 117–118.

existence of significant impediments to trade that operate largely outside existing GATS disciplines. The following are some examples:

- lack of recognition of foreign credentials impeding the movement of professionals abroad and discouraging students from obtaining foreign credentials;
- lack of quality-assurance standards and procedures for assessment which discourage countries from permitting foreign suppliers to deliver services in all modes;
- restrictions on the physical and electronic transmission of educational materials;
- difficulties in obtaining authorization to enter and leave the country for individual services suppliers—including managers, computer specialists, academics and health professionals;
- rules regarding the employment of academics.[58]

The lack of strong evidence of benefits associated with GATS commitments combined with the fact that many barriers to trade in health and education services cannot be readily addressed through existing GATS disciplines discourages countries from negotiating GATS commitments.

3. Uncertainty regarding the extent to which specific commitments in GATS may preclude future changes in health and education policies

One of the particular concerns expressed regarding accepting commitments in health and education is that once a state takes this step, its flexibility subsequently to shift direction is lost. Potentially, this could be an important consideration for governments because experiments with market-opening reforms, at least in health care, have often been followed by subsequent rounds of reforms to correct for problems arising with initial reforms.[59] Critics of the GATS worry that if a country decided to commit to national treatment and market access for foreign hospitals operating through a commercial presence, for example, it would be precluded from deciding subsequently to return to a regime requiring the delivery of hospital services through domestic suppliers or under which the state provides the services.

[58] These are some of the barriers to trade in education noted in United States: Proposal on Higher (Tertiary) Education, Adult Education, and Training, *supra* n. 39, and Australia: Negotiating Proposal for Education Services, *supra* n. 36. Adlung describes some of these barriers to trade in health services in Adlung, *supra* n. 1.

[59] Epps and Flood discuss experience with several specific types of market reforms in health care which involve increased foreign private participation and the frequent need for a second round of reforms: T. Epps and C. Flood, 'Have We Traded Away the Opportunity for Innovative Health Care Reform? The Implications of the NAFTA for Medicare' in 47 *McGill Law Journal* (2002) 747.

One short answer to this concern is that GATS does not prohibit such a policy change. The agreement expressly contemplates that a Member may withdraw trade concessions made in its national schedule in relation to any service sector at any time on three months' notice to the WTO Council on Trade in Services. Where another WTO Member feels the withdrawal may affect the benefits it receives under the agreement, it may request that the withdrawing Member enter into negotiations with a view to agreeing on a compensating adjustment typically in the form of other trade concessions. Compensatory adjustments must be extended to all WTO Members on an MFN basis. In the event of failed compensation negotiations, the affected Member country may seek arbitration. Where arbitration has been requested, the withdrawing Member cannot make the modification until it has given trade compensation in accordance with the arbitration award. If the withdrawing Member does not do so, any Member who participated in the arbitration may withdraw substantially equivalent concessions in retaliation. If arbitration is not requested by another Member, the withdrawing Member is free to implement the proposed change to its schedule of commitments.

A state could avoid the risk of such a compensation claim by expressly recording any flexibility it foresees as possibly important in the future in the form of an express limitation on its obligations in its national schedule at the time it undertakes specific commitments for health and education.[60] Taking advantage of this feature of GATS, however, requires a very high level of understanding of the demographic, economic, and technological trends affecting such services, which few developing country governments may possess. The challenge of inscribing appropriate limitations may be exacerbated by a lack of engagement by line health and education ministries in the trade policy development process. To the extent that scheduling limitations is not a straightforward strategy to safeguard policy flexibility that is thought to be required, countries may choose not to list health and education sectors in their schedules, notwithstanding their right subsequently to withdraw their commitments.

C. Summary

The result of these three uncertainties of GATS is that even where developing countries are willing to liberalize trade in health and education services, the case for expressing such willingness in the form

[60] The possible application of the general exceptions in GATS Art. XIV would also have to be considered.

of GATS commitments may not be convincing. Many developing countries may see GATS commitments, including commitments simply to maintain the status quo, as having few certain benefits while imposing constraints, the precise scope of which is hard to predict. While the architecture of the agreement permits Members to preserve their policy flexibility by inscribing limitations on their obligations in their national schedules, doing so imposes a burden that developing countries may be unwilling to bear. In light of the risks to the achievement of the important social policy objectives of domestic health and education systems that are associated with trade liberalization, developing countries may be reluctant to make commitments that may restrict their policy options in any way.

VI. CONCLUSIONS: TOWARD A GATS THAT IS MORE RELEVANT TO HEALTH AND EDUCATION

GATS is not inherently unfriendly to the regulation and delivery of health and education services in ways that achieve development objectives in developing countries. Trade liberalization in health and education services secured under GATS commitments can have some real benefits and many of the negative effects can be addressed through GATS-consistent regulation. GATS does permit Members to decide whether to accept commitments in any area and, if they do, to tailor them in ways consistent with their national policies. It is not surprising, then, that a number of developing and least-developed countries have chosen to make commitments in both areas. Still, most developing countries have not undertaken commitments. Among the main impediments to a GATS that operates more effectively as an instrument to facilitate trade in health and education services consistent with development objectives are the three uncertainties described in the preceding section.

The first step to addressing this problem is to improve understanding of the operation of GATS especially among the health and education communities in developing countries. Efforts by the WTO, the OECD, and others to date have proved insufficient to dispel the misinformation regarding issues like the impact of the agreement on public services that has played such a significant role in the debate over GATS and its effects on health and education. More work is needed to give practical operational content to GATS obligations in order to assist developing country policy-makers to appreciate the impact and the limits of GATS obligations. While this could be undertaken by international organizations and development agencies, some of this work is

already being done by developed country governments, such as Canada's, for their internal purposes and could be made available to developing countries.

In terms of other definite steps that may be taken to address the uncertainties of GATS, one option would be to develop reference papers for health and education as was done in the telecommunications sector. The telecommunications reference paper addressed a range of sector-specific issues. It provided some basic, commonly accepted definitions and clarified and established the modalities for the application of key obligations in terms specific to the telecommunications sector. Ultimately, the reference paper was incorporated by reference in the national schedules of many Members. The same approach could be used in relation to health and education services. Developing a common template for specific commitments would economize on scarce negotiating resources in developing countries. As well, in the telecommunications negotiations, the reference paper provided reassurance to domestic regulators regarding the scope and impact of GATS obligations by acknowledging the importance of relevant policy goals in the telecommunication sector, including the right of Members to impose universal service obligations.[61] Given the highly charged negative response to the application of GATS in the areas of health and education, there is widespread suspicion regarding GATS. The adoption of instruments specifically tailored to the exigencies of health and education would help to reassure key national stakeholders. Such confidence building will be an essential condition to the development of Members' interest in GATS commitments.

It is not clear that it is possible to address the uncertainties regarding the application of GATS domestic regulation rules through a reference paper. As a part of the specific commitments of those individual WTO Members that incorporate it in their schedules, a reference paper could only express limitations relating to the Member's market access and national treatment obligations or additional commitments. Nothing in a national schedule can affect the domestic regulations obligations. It would be more appropriate to address the uncertainty related to current domestic regulation rules in the context of the negotiations on these rules. Sector-specific disciplines, like those adopted for accounting services, could be developed to define what kinds of measures relate to the quality of health and education services and how to apply the rule that qualification requirements and procedures, technical standards, and licensing requirements cannot nullify or impair the Member's

[61] Luff, *supra* n. 49, and Adlung, *supra* n. 1. Lipson has suggested going much farther to adopt some form of special and differential treatment for developing countries (Lipson, *supra* n. 22).

specific commitments in listed sectors by imposing requirements or standards that are more burdensome than necessary to ensure the quality of the service. To date, such sector-specific work in health and education has not been on the agenda of the Working Party on Domestic Regulation.

Alternatively, separate international instruments dealing with these issues could be negotiated in other multilateral fora, such as the UN Educational, Scientific and Cultural Organization (UNESCO) or the WHO. GATS Article VI.5(b) expressly requires that in determining whether a Member is in conformity with its obligations related to domestic regulation, 'account shall be taken of international standards of relevant international organizations applied by that Member'. In this way, the development of international standards to which a Member subscribed would assist in defining the scope of the Member's obligation.

As well, the development and adoption of a more specific and refined classification system for health and education services would facilitate more consistent scheduling of commitments and contribute to a common understanding among the Members of the WTO regarding the nature of obligations undertaken. Again, especially for developing countries, collective efforts to resolve existing uncertainty are more likely to encourage commitments than leaving it up to individual members to establish their own categories. At the same time, clarity and predictability of GATS obligations would be enhanced by more uniform categories of commitments. This work might be undertaken by the Committee on Specific Commitments, but, so far, has not been. Classification issues could also be addressed in a reference paper.

Support for individual developing countries would also help them to make more effective use of specific GATS commitments in health and education. A significant challenge for many developing countries is the absence of adequate capacity to assess the costs and benefits of GATS commitments in health and education and to conceive and implement an appropriate regulatory regime capable of ensuring that the benefits of trade liberalization are attained in a manner consistent with the achievement of the range of objectives informing government policy related to these areas. At the country level, international development agencies may support local assessment of the costs and benefits of liberalization initiatives, including identifying areas of export potential, such as traditional medicines, and the feasibility of complementary measures in the context of local regulatory capacity and other local conditions. In a recently completed pilot project, the International Trade Centre carried out assessments of trade liberalization with ten developing countries. While this work focused on business-to-business

services rather than business-to-consumer services like health and education, it is an example of the kind of support that could be provided.

Whatever improvements are made relating to GATS, inevitably, the agreement will serve only as a complement to other liberalization initiatives. The role of GATS is necessarily limited because many of the impediments to increased trade in health and education lie outside the disciplines of the agreement. International development agencies and international organizations will play a number of key roles in addressing these barriers. Continued research on the effects of liberalization in health and education services not only on trade and investment, but also on accessibility, internal and international migration of health and education professionals, and the scope for domestic policy measures to complement and manage the effects of liberalization by organizations like the WHO, UNESCO, the OECD, the World Bank, and others will be essential.[62] One of the largest impediments to trade in health and education will continue to be the absence of recognition of foreign credentials and experience of health and education professionals. Quality-assurance and accreditation standards are still largely national. UNESCO has played a useful role in coordinating the development of international standards agreements in education.[63] The WHO has developed accreditation guidelines for hospitals and medical laboratories that can be applied by national agencies. These kinds of efforts facilitate international trade in health and education and help to provide a basis for regulating the globalized aspects of these activities so as to ensure that consumer protection and other domestic policy priorities are promoted. International development agencies may also play a role in facilitating adoption of technology forming the backbone of electronic supply of health and education services. This mode of supply promises significant benefits in terms of increasing access while involving few negative effects for developing countries.

All these efforts and others outside the scope of GATS are likely to have a more substantial impact on trade in health and education services than commitments under the GATS. Nevertheless, GATS has the potential to play an important complementary role. Taking the steps identified above could assist in the realization of this potential. Whether

[62] Chanda, *supra* n. 15.

[63] See e.g. *Convention on the Recognition of Qualifications Concerning Higher Education in the European Region*, co-sponsored by the Council of Europe and UNESCO, which was concluded in April 1997 to facilitate international exchanges of students and scholars by establishing standards for the international evaluation of secondary and post-secondary credentials. Signatories include the EU, many Eastern European countries, Australia, Israel, the US, and Canada. Appendix II to WTO Secretariat Note on Education Services, *supra* n. 46, lists other recognition instruments.

WTO Members are willing to take these or other steps to facilitate GATS commitments in health and education, however, is not obvious. To date, health and education have not received significant attention from WTO Members. No doubt, this is because the commercial opportunities in these sectors pale in comparison to those in other areas. As well, there is a fierce debate in many countries regarding the virtues of private commercial participation in health care and education. This has created a difficult domestic political environment in many countries that may discourage them from attaching priority to improving health and education disciplines in the WTO. Nevertheless, widespread concerns about the impact of the GATS on health and education have been the source of impassioned critiques of the agreement that have seriously tainted the public view of GATS. The public rehabilitation of the agreement in addition to the economic benefits that may flow from GATS-secured liberalization in health and education argue in favour of greater attention to the application of GATS to health and education services.