THE GATS THREAT TO PUBLIC HEALTH

A JOINT SUBMISSION TO THE WORLD HEALTH ASSEMBLY

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Within just 10 years of its adoption, the General Agreement on Trade in Services (GATS) has become one of the most controversial elements of the international trading system. More and more countries are becoming aware of the threat posed by the scope of the GATS agreement, and there is a growing call for governments to defend essential services from the GATS liberalisation agenda.

This briefing examines the threat which GATS poses to health. It looks first at the challenge to health services themselves, including the potential for increased inequity, fragmentation of health systems and further marginalisation of the public sector as a result of the increased marketisation of health care.

The briefing also examines the health risks which come with liberalisation of other service sectors such as water and insurance, and reveals the challenge to national health regulations from current negotiations at the World Trade Organisation (WTO).

In conclusion, the briefing recommends that no country should commit its health services to GATS. In addition, each country should actively involve its health ministry and civil society in comprehensive 'health checks' of any GATS commitments proposed in other sectors before deciding on them.

How does GATS work?

GATS commits WTO members to successive rounds of negotiations "with a view to achieving a progressively higher level of liberalisation" in their service sectors. To achieve this, WTO members make liberalisation requests of other member countries in secret, bilateral meetings in Geneva so as to open up to competition those sectors which are of most interest to their own service providers.

The current round of negotiations is now entering its most intense phase, when countries battle over which service sectors they will give up to liberalisation and which they will protect from GATS. Although developing countries officially have the right to choose whether to commit a sector to GATS, in practice they come under intense pressure in these negotiations to meet the demands of more powerful WTO members – pressure which the smaller and poorer countries are often powerless to resist.

In this way, GATS is primarily a mechanism for the service corporations of developed countries to expand their reach into new markets around the world. This is widely acknowledged by official negotiators: the European Commission has confirmed that GATS is "first and foremost an instrument for the benefit of business, and not only for business in general, but for individual service companies wishing to export services or to invest and operate abroad."

GATS and health services

When GATS was adopted in 1994, few countries were aware of the challenges it would bring. Very few government departments other than trade and finance ministries were involved in the negotiations, and several countries committed all or part of their health services to GATS liberalisation without the knowledge of their health ministries.

According to the WTO Secretariat, 42 countries have already committed their hospital services to GATS. In addition, 15 have made commitments under the category of 'other human health services', which include laboratory, epidemiological and residential health services, as well as podiatry and chiropody services supplied in clinics and elsewhere.

Health services are also included under the GATS heading of 'professional services', which covers medical and dental services as well as the category of 'services provided by midwives, nurses, physio-therapists and paramedical personnel'. Already 52 countries have made liberalisation commitments in the former category, and 28 in the latter.

GATS also covers insurance services, including health insurance, and 78 countries have already committed those services to liberalisation under GATS. This has caused particular concern in those countries which base their health systems on social insurance programmes, since few health ministries were informed that their trade negotiators had committed their health insurance sectors to GATS.

The above figures may suggest that many countries have largely committed their health sectors to GATS already. Yet out of all sectors covered by GATS, health and education are the two in which fewest commitments have been made. As a result, the WTO sees the current GATS negotiations as an opportunity to achieve further liberalisation in those sectors.

In fact, many countries have deliberately withheld their health services from GATS liberalisation in recognition of the great uncertainty surrounding what a GATS commitment might mean for health care. It is only now, in the current round of GATS negotiations, that health services may again come under threat of liberalisation.

The GATS threat to health services

Providing basic services for all requires strong government regulation and a proper understanding of where liberalisation may be beneficial, and where not. Yet the 'request-offer' process of GATS negotiations is designed to open up more and more service sectors to competition through a series of trade-offs at the WTO, rather than concentrating on which type of system is most appropriate for which particular service.

This is of special concern in the case of health services, where the market-based model of competition threatens the integrity of health systems themselves. Health is a human right and a public good whose positive externalities cannot be captured through market mechanisms. As such it is not suitable to commit health services to binding liberalisation under GATS.

Nowhere is this more clearly seen than in the threat of competition from foreign hospitals. Even in countries where the public sector already faces competition from domestic private hospitals, the additional challenge of hospital services provided by foreign private sector health providers exerts extra pressure on public health systems which are already under severe strain.

For those patients who can afford them, high-tech foreign hospitals may offer an unparalleled level of health service. They also offer medical personnel an opportunity to practise their profession in the most modern and fulfilling environment, and often at far higher rates of pay.

Yet by attracting the most experienced staff and the most affluent patients away from the public sector, expansion of the private sector undermines the integrity of the health system as a whole. As WHO affirmed in its *World Health Report 2000*, leaving the public sector to provide services only to the poorest and most needy patients undermines the possibility of cross-subsidisation and risk pooling on which sustainable health systems are based.

For the vast majority who are unable to afford the high costs of foreign private sector health care, the promise of 'increased choice' as a result of liberalisation is therefore a hollow one. Rural communities in particular risk seeing their access to health care undermined by the expansion of the private sector, as foreign hospitals draw away their remaining doctors, nurses and midwives to serve the urban elite.

THE FOUR GATS MODES OF SERVICE DELIVERY

GATS distinguishes four different 'modes' of services, all of which are relevant to health services:

1. **cross-border supply:** – where the service is provided remotely from one country to another, such as telemedicine via Internet or satellite, or international health insurance policies
2. **consumption abroad:** – where individuals use a service in another country, such as patients travelling to take advantage of foreign health care facilities, or medical students training abroad
3. **commercial presence:** – where a foreign company sets up operations within another country in order to deliver the service, such as hospitals, health clinics, insurance offices or water distribution operations
4. **presence of natural persons:** – where individuals such as nurses, doctors or midwives travel to another country to supply a service there on a temporary basis

Health risks of other GATS liberalisation

The financing of health systems faces a similar challenge from GATS liberalisation. National health insurance systems can be seriously undermined by such liberalisation, as competition from foreign providers threatens the sustainability of programmes designed to spread costs across society and provide affordable health care for all.

Yet it is not only in respect of health systems that GATS poses a threat to health. GATS covers a wide range of other service sectors with direct links to health outcomes, and liberalisation poses a threat in many of these sectors too. Public statements by the European Commission that the EU is making no GATS requests in health services fail to acknowledge the potential health impact of its extensive requests in other sectors.

For example, the EU is attempting to use the current round of GATS negotiations to open up the water sectors of 72 other WTO member states – including both developing and least developed countries. There is evidence from developing countries across Latin America, Africa and Asia that liberalisation of water systems typically raises water tariffs beyond the reach of many poor households and can cause severe health problems, especially among children.

As a result of such experiences, several developing countries which experimented with liberalisation in their water services have taken the service back into public hands. Yet once a sector is committed under GATS, punitive rules on the modification of national commitments make it effectively impossible for a country to reverse liberalisation in this way.

This is because WTO agreements are designed to bind liberalisation commitments for the future so as to give foreign investors increased security – even if this means exposing vulnerable communities and their children to increased levels of risk. Many commentators see this 'lock-in' mechanism as the most dangerous aspect of GATS, since it closes down the possibility of reversing excessive or damaging liberalisation in the future.

GATS and public health regulation

As shown above, GATS has gone further than any other multilateral trade agreement to bring the WTO's liberalisation agenda into the heart of national policy. This is particularly true of the GATS rules on domestic regulation, which are still being developed at the WTO.

GATS states that domestic regulations in WTO member countries must not pose "unnecessary barriers to trade". It also mandates the WTO's Council for Trade in Services to develop new GATS rules to ensure that technical standards or licensing requirements in WTO member countries are "not more burdensome than necessary to ensure the quality of the service".

Yet there is widespread concern that these GATS rules will threaten key public health regulations in WTO member countries. The GATS requirement that regulations must be 'necessary' in WTO terms could expose any domestic health policy to challenge at the WTO.

India's progressive new regulations on the marketing of baby foods are just one example of the type of 'restrictions' which could be under threat. The new regulations, approved by India's parliament in May 2003 in order to support breastfeeding, prohibit the promotion of breastmilk substitutes, feeding bottles and all foods for babies under the age of two years.
Yet such regulations could be interpreted as 'unnecessary' if the WTO decided that there were other ways of achieving the same public health objectives – even if there were specialist evidence to the contrary (see box on page 3).

This has raised fears that other key public health controls, such as restrictions on the marketing of alcohol and tobacco or regulations governing private hospitals, could also be threatened by GATS rules on domestic regulation, once they have been adopted at the WTO.

'NECESSARY' REGULATION?

The USA's 1990 challenge to Thailand's longstanding ban on tobacco imports shows how the WTO could interpret whether a domestic regulation is 'necessary' or not. WHO supported the Thai government in its defence that opening its market to imported cigarettes (and the advertising which goes with them) would inevitably lead to an increase in smoking, especially among women and young people, and that the import ban was therefore necessary to protect public health. Yet the pre-WTO dispute panel ruled that the ban was a restriction on trade which was not 'necessary', and called on the Thai government to remove it. The WTO has since cited the decision as precedent for its own rulings in similar cases.

WHO officials have openly voiced their opinion that the WTO cannot be trusted to uphold legitimate public health provisions, and many other organisations have called for a halt to the domestic regulation negotiations at the WTO.

GATS and the migration of health personnel

In addition to the establishment of hospitals, clinics or insurance offices, trade in services also covers the movement of individual people to provide services abroad. In the case of health services, this 'trade' takes place when doctors, dentists, nurses, midwives or other health personnel move to other countries in order to practise there. In the GATS context, this is referred to as 'mode 4' (see box on page 2).

Many developing countries are using the GATS negotiations to argue for greater freedom for their nationals to work abroad, as they see this export of labour as an area of comparative advantage for their economies. Countries such as India, Mexico and the Philippines already receive over $5 billion per year each in workers' remittances, while in countries such as Tonga, Lesotho and Jordan, workers' remittances represent over 20% of national GDP.

Yet the export of labour is not necessarily appropriate in all sectors. In particular, the migration of health personnel to richer countries is already a significant and well attested problem facing health systems across the world.

Rather than promoting further migration in the pursuit of balance of payments gains, the vast majority of developing countries need to find ways of retaining key personnel in their own health systems, where their presence can make an immediate and lasting difference to the lives of many of the world's most vulnerable people.

Conclusion and recommendations

The current round of GATS negotiations have now entered their most intense phase, with countries being asked to liberalise sectors which they have previously kept closed to competition.

Yet the model of binding trade liberalisation at the WTO may not be appropriate for services which have a major impact on human health. For precisely this reason, several countries have stated that they are not going to offer up key service sectors to GATS.

ASEAN health officials meeting in Jakarta in 2002 concluded that developing countries should refrain from making health commitments under GATS, and called on all health ministries to ensure that their health sectors are not traded away at the WTO. The same policy has been adopted by the EU, USA and many other countries, all of which have stated they will not offer up their health services under GATS.

There have been similar calls for caution in other sectors, with South African officials calling for water to be taken out of GATS altogether. The same caution has been called for in other environmental services, as well as sectors such as tourism, energy, education and cultural services, all of which could be threatened by GATS liberalisation commitments.

In recognition of these dangers, it is recommended that all WTO member countries should:

1. **make no GATS commitments in the health sector or other health-related sectors;**
2. **conduct a comprehensive 'health check' on any other GATS commitments proposed by WTO trade negotiators, with the active involvement of health ministries and civil society;**
3. **call a halt to the current WTO negotiations on rules governing domestic regulation;**
4. **call for a change to GATS rules which restrict countries from retracting commitments already made under GATS.**

This statement is endorsed by the following organisations: Equinet, International People's Health Council, Medact, People's Health Movement, Save the Children UK, Wemos, World Development Movement.