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HEALTH AND SOCIAL SERVICES

Background Note by the Secretariat

I. INTRODUCTION

1. This Note forms part of the information exchange programme currently conducted by the Council for Trade in Services. Complementing similar Notes on other sectors, it gives an overview of recent economic and regulatory developments, including commitments under the GATS, in the medical, health and social services sectors. Delegations are recommended to read it in conjunction with more detailed studies issued by international organizations such as the World Health Organization (WHO), UNCTAD, World Bank and OECD.

2. Many recent discussions of sectoral policy developments have focused on the need to curtail spiralling health care spending without sacrificing basic quality and equity goals. A particular concern for industrial countries has been the adverse impact of rising health care costs on the pursuit of other policy objectives related to growth, employment and/or public sector retrenchment. In many developing countries, the non-availability of basic services to large population segments, and the resulting social and developmental implications, have remained serious policy challenges.

3. Trade-related considerations have not proved a dominant policy concern, apart from issues related to the international migration of staff. Even in the most economically advanced countries, the health services sector - a domestic economic giant representing, for example, close to 6 per cent of U.S. GDP – has remained a minor contributor to trade. This seems to reflect the combined effects of regulatory restrictions preventing movements of professionals and patients, institutional constraints (monopoly and exclusivity arrangements) discouraging foreign commercial presence, as well as technology-related barriers inhibiting the cross-border provision of many health and social services. However, the picture seems to be gradually brightening over time, owing in particular to two complementary developments: first, regulatory regimes in various countries have been moving towards stronger market orientation – opening space for increased private involvement, domestic and foreign – and, second, technical changes are increasingly enabling certain services, or at least sub-segments, to be transmitted electronically between countries and continents.

4. The forthcoming round of negotiations under the GATS offers an opportunity for WTO Members to reconsider the breadth and depth of their commitments on health and social services, which are currently trailing behind other large sectors. Increased liberalization may be supportive of the changes indicated above while, in an appropriate environment, allowing developing countries to strengthen their domestic services capacity and better using their competitive advantages. While this Note may help to stimulate discussion of these issues, it would need to be complemented by the exchange of more specific information among Members in individual areas.

5. The main part of the Note is structured as follows: Section II provides some country information on the economic role of the health sector and the importance of trade under individual modes of supply. Section III discusses basic institutional and regulatory approaches in the health care and health insurance sectors, the role of domestic regulation and recognition, and the ensuing

implications for market entry and competition. Sector IV analyses the level and structure of current commitments under the GATS.

6. Subject to the availability of information, the Note covers all health and social services as defined in Division 93 of the United Nations Provisional Central Product Classification (CPC). This means that the coverage is wider than the delineation contained in the Services Sectoral Classification List (MTN.GNS/W/120), which Members have generally used for scheduling purposes under the GATS. The definition of Health-Related and Social Services in this List does not include medical and dental services, veterinary services and the services provided by nurses, midwives etc., which have been grouped separately under Professional Services. From an economic and trade perspective, however, this separation is not entirely convincing. It disregards the strong complementarities that may exist, for example, between medical services on the one hand and hospital services on the other. Moreover, the criteria used for allocating certain activities, in particular veterinary and social services, to either health-related services or professional services do not seem to be fully consistent (Annex).

II. MAIN ECONOMIC FEATURES

A. OBJECTIVES AND CONSTRAINTS GOVERNING PRODUCTION AND TRADE

7. Medical, health and social services may serve a multitude of different – developmental, distributional, social and other – functions. While they may all be considered highly relevant and important, their relative weight may vary over time and between countries, depending on parameters such as income, age, technology, and the prevailing set of economic and social (equity) objectives. Accordingly, such services may be core instruments in the pursuit of social and distributional justice or could be viewed as important contributors to, or preconditions for, economic development. Researchers may analyse them as genuine activities in their own right, focus on their resource implications and budgetary consequences, or seek to explore supply and demand links with other sectors of the economy. Thus, in a nutshell, health and social services are subject to a panoply of economic and non-economic goals, influences and constraints.

8. If there is one common denominator running throughout many current discussions, it is efficiency considerations. Prompted by budgetary constraints and/or supply bottlenecks in certain areas, including specialized professionals, governments around the world have increasingly come to recognize the need for more productive resource use. Relevant initiatives in this context include organizational changes expected to yield economies of scale and scope, the introduction of monetary incentives in hitherto tightly regulated areas (commercialization of hospital functions) or reforms in public insurance and subsidy schemes to encourage more prudent resource use. While many of these initiatives may lead to greater market orientation, various countries have also introduced administrative controls and other command-and-control measures to deter new entrants, curtail "excessive" demand for pharmaceuticals or hospital beds, or influence geographic patterns of supply (Box I).

9. External opening may play an important role in any market-based reform strategy. While health and social services have long been considered as (a) non-tradeables to be provided by (b) public institutions, there has been a change in policy perception in a number of countries. More efficient transport and communication technologies have enhanced the mobility of both professionals and consumers and enabled the use of new modes of supply (telemedicine), overturning traditional concepts of space and distance. At the same time, new forms of private sector involvement have opened breaches for increased domestic and foreign participation.

B. HEALTH AND MEDICAL SERVICES: CONTRIBUTION TO GDP AND EMPLOYMENT

10. Many analysts, especially in OECD countries, may be inclined to see the health sector not predominantly as a "contributor" to GDP but as a drag on economic expansion. Throughout the OECD area, health expenditure has been on the rise over the past two decades, absorbing increasing

shares of private consumption and, in particular, government spending (Table 1). In turn, this has gradually narrowed the scope for other policy initiatives, possibly including tax cuts and broader public sector reforms, which may be considered high-priority tasks for governments seeking to stem rising unemployment and flagging economic growth.[1]

11. In the mid-1990s, the OECD countries spent some US$2,000 billion annually on health, which was close to 90 per cent of total world health expenditure. In most OECD economies, health care spending accounts for more than 8 per cent of GDP at present (1.5 to 5.5 per cent in the early 1960s), as compared to some 5 per cent in developing countries.[2] This includes public and private spending on both goods and services. (Public health expenditure is defined to comprise recurrent and capital spending from public budgets, external borrowings and grants, including donations, and the spending of social or compulsory health insurance.) While there are wide variations among countries, hospital services tend to account for between 40 and 50 per cent of total health spending in the OECD area, pharmaceuticals between 30 and 40 per cent, with the remainder consisting mainly of out-patient medical and paramedical services.[3]

12. On a global scale, per capita health expenditure varies dramatically, between some US$5 *per annum* in some least developed countries, including Bangladesh, Ghana and Nigeria, and US$3,500 and more in Switzerland and the United States.[4] It is very difficult to assess, however, to what extent such differences are actually reflected in the quantity and quality of medical supply and, as a possible result, the health status of the population. For example, Sri Lanka recorded an estimated life expectancy of 73 years in 1996, which is several years longer than in some other countries spending 20 or 30 times more on health.[5]

13. Health-related spending in the United States tends to exceed 14 per cent of GDP. Medicare alone, the public health-insurance scheme for the elderly and disabled, accounts for about 2.5 per cent of GDP. The funds involved rose more than 30-fold since 1970 to reach US$200 billion in 1997. Nevertheless, the public share in total health spending has remained lower in the United States, at some 45 per cent, than in any other industrial country. The OECD average is in the order of three quarters, as compared to some 50 per cent in developing countries.

14. Studies by OECD experts have attributed a significant portion of U.S. health expenditure to unusually high input prices. Among OECD countries, the United States displays the largest gap between domestic prices in general which, at current exchange rates, are comparatively low in the U.S., and prices for health inputs. The opposite is true for Japan which, after adjustment for relative price effects, records the highest "volume" of aggregate health expenditure per capita in the OECD

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[1]Unless otherwise indicated, the data presented in following paragraphs are based on OECD (1995), *New Directions in Health Care Policy*, Paris; and Schieber, George (1997), *The Social, Economic, and Institutional Context of Health Care Financing Reforms*, paper presented at a World Bank-sponsored conference on "Innovations in Health Care Financing", Washington D.C.

[2]It may be worth noting that health care spending – which includes the inputs provided by other sectors – is significantly higher than the health sector's genuine contribution to GDP. Estimates on a gross value-added basis indicate a share of health services in GDP, in 1994, of 5.6 per cent in the United States (private market and non-market services), 3.6 per cent in France, 2.4 per cent in Germany and 2.1 per cent in Canada (market services only). According to OECD (1997), *Services Statistics on Value Added and Employment*, Paris.

[3]These figures need to be interpreted with care as they are subject to serious definition problems.

[4]Annual average 1990-95, taken from World Bank (1998), *World Development Indicators*, Washington D.C.

Given the amounts spent on health care in some countries, the question may arise whether alternative approaches aimed at improving the health situation (investments in environmental measures, traffic safety, non-smoking and anti-drug campaigns, etc.) carry higher returns. Moreover, rising taxes and charges, including contributions to mandatory insurance schemes, may influence lifestyles in a way not necessarily conducive to health. Efforts to maintain real disposable incomes may increase stress at the workplace.

[5]Sri Lanka's per capita expenditure on health is estimated at US$12 per annum. An overview of health-related indicators for broad country groupings is given in Table 2.

area.[6] (However, the price gap between health/medical services and other components of domestic consumption may be influenced by quality factors. Health and medical services demanded and supplied in the United States may simply be better, reflecting public regulation and/or private value judgement, than the quality normally expected from other goods and services.)[7] Health care prices also appear to be relatively low in Turkey and the United Kingdom.

15. Mirroring the general increase in spending, employment in the health sector has risen continually over time. It is estimated that within the EU as a whole, the sector represents about 8 per cent of the workforce. Of this, nurses and midwives are estimated to account for more than one quarter and physicians for about one eighth (1991).[8]

16. EU experts hypothesize continued demand expansion in the Union, at rates close to or slightly higher than real GDP (about 3.5 to 4% per year). However, the scope for price increases is expected to be very limited. This may help to stabilize total health expenditure at about 7.5 per cent of GDP in the long run, although with a shrinking share of public financing.[9]

17. The trend of increasing real spending on health care has been attributed to a variety of factors. These include on the demand side:

(a) expanded reach of mandatory insurance schemes as health care is increasingly perceived, like education, as a basic social entitlement (with the exception of the United States, all OECD countries have achieved universal coverage);

(b) aging populations in many countries (the health care costs of persons above 65 tend to be four times higher than in lower age groups);

(c) the emergence and/or discovery of new diseases as well as a shift towards chronic and multi-faceted ailments; and

(d) lack of incentives for patients to economize as the cost of treatment is (almost) fully covered by insurance schemes.

On the supply side, experts have long noted:

(a) a similar lack of incentives to relate the cost of treatment to the expected benefits;

(b) the introduction, and sometimes unreflected use, of ever more sophisticated and expensive technologies;

(c) insufficient health care planning and coordination, as reflected, for example, in "over-equipment" and excess capacity of hospitals and practices; and

(d) unfocused treatment by doctors ("variable practice patterns"). It has been estimated that countries may waste 30 to 60 per cent of their health care spending on ineffective or inappropriate treatment.[10]

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[6]OECD (1995), *New Directions in Health Care Policy*, Paris.

[7]In the early 1990s, the United States had less than five hospitals beds per 1,000 inhabitants as compared to over15 in Japan. However, the ratio of hospital staff per bed was 3.5 in the United States and 0.8 in Japan (OECD, 1995).

[8]European Commission (ed., 1997), *Panorama of EU Industry*, Luxembourg.

[9]European Commission (1997).

[10]Abel-Smith, Brian (1996), *The escalation of health care costs: How did we get there?*, in OECD, Health Care Reform – The Will to Change, Paris.

C. TRADE IN HEALTH AND MEDICAL SERVICES: SOME EMPIRICAL EVIDENCE

18. Empirical evidence suggests, that the volume of international trade in medical and health services is still relatively modest. For example, U.S. "exports" of health care services, covering the activities of U.S.-majority-owned suppliers abroad and the services provided to foreigners in the United States, are estimated to amount to less than two per thousand of total domestic health care spending.

19. A recent WHO publication points out the increasing importance of cross-border supply of medical services. For example, U.S. suppliers provide commercial telemedicine services to customers in several Arab Gulf countries; and Jordan has established telemedicine links with the Mayo Clinics in the United States. There is also some trade in telediagnosis services between costal provinces in China (PR) and patients in Chinese Taipei, Macau and other South-East Asian economies; and several Central American countries have begun sending medical samples for diagnosis to Mexico's public health hospitals.[11]

20. To date, telemedicine appears to have been used mainly to overcome geographical barriers within individual countries and improve health care in remote regions, for example in Norway and Australia. However, the above examples illustrate a significant potential for cross-border trade. Such trade may extend well beyond the area of health care *per se* and include hospital management functions, data collection for statistical or educational purposes, and back-up advisory facilities for local staff abroad. Not all of these activities may be classified as medical and health-related services but, as the case may be, as data base services, management consulting or education services. The GATS Annex on Telecommunications obliges Members that have committed on such activities to ensure that their public telecommunications networks and services are made available on reasonable and non-discriminatory terms and conditions.

21. Although there are no aggregate estimates available, it appears safe to assume that consumption of health services abroad has remained a more economically relevant mode of supply. Trade may take the form of patients moving (a) from developing to developed countries, for example with better-off people seeking rapid access to high-quality services abroad; (b) from developed to developing countries, with patients demanding "exotic" therapies or, simply, less expensive treatment in cases not covered by health insurers (e.g. cosmetic surgery) as well as (c) within the two country groups in cases, for example, where domestic suppliers are unable to provide a required service in time or compete effectively in terms of price or quality. In addition, individual countries, developing and developed alike, may benefit from their natural endowment and climate.

22. A study cited by WHO experts suggests that India has considerable potential for attracting foreign patients, both from neighbouring countries and from the wider Asia-Pacific region. Reportedly, Indian clinics may offer sophisticated treatment, including cardiovascular surgery, as well as standard and specialized therapies at prices estimated at about one-fifth to one-tenth of those charged in industrial countries for similar interventions. In the same vein, a Cuban agency – Servimed – has teamed up with travel agencies and tour operators abroad to promote package sales of

[11] WHO Task Force on Health Economics (1997), *Health Economics - Technical Briefing Note – Measuring trade liberalization against public health objectives: the case of health services,* Geneva; and Mandil, Salah H. (1998); *Telehealth: What is it? Will it propel cross-border trade in health services?* in Zarrilli, S., and C. Kinnon (ed), "International trade in health services: a development perspective", Geneva (UNCTAD/WHO).

Delegations may also benefit from the discussion in the WHO Briefing Note on broader equity, quality and efficiency considerations related to the introduction and proliferation of telemedicine.

medical treatment and stays in resorts and spas.[12] Nevertheless, industrialized countries, especially the United States, have remained the prime suppliers of health services to foreign patients.

23. In 1996, U.S. exports of health care services – mainly in the form of foreign tourists obtaining treatment during stays in the United States – amounted to an estimated US$872 million. U.S. imports of such services were estimated at some US$550 million, indicating a significant surplus.[13] Canadians represented some 50 per cent of the foreigners treated in the United States, followed by Europeans, mainly from the United Kingdom and Germany, Mexicans, Australians and Japanese. Although the majority of these foreigners fell sick while visiting the U.S., leading medical institutions like the Mayo Clinics, Johns Hopkins Medical Center, and Massachusetts General Hospital are reported to attract significant flows of patients genuinely travelling for treatment. (The four Mayo Clinics expected 10,000 patients from abroad in 1997). The U.S. Department of Commerce sees an increasingly promising market potential in Latin America, noting that Argentinians are estimated to spend US$60 million annually on medical treatment abroad, and that more than 400,000 Mexicans could afford treatment in the United States.

24. Establishment trade, i.e. the commercial provision of health services via foreign-invested clinics or practices, is likely to occur especially between developed countries. However, the Secretariat has found quantitative information only for the United States. Accordingly, U.S. exports - i.e. sales by foreign-based affiliates of U.S. majority-owned health care providers - amounted to US$469 million in 1995, representing a decline of 1 per cent over the previous year. (Given the relatively modest numbers involved, annual fluctuations may be attributed to the completion of a few large investments.) This contrasts, in the same year, with services sales worth US$1.8 billion by foreign-owned health care suppliers in the United States. The U.S. deficit is ascribed mainly to the activities of two hospital chains, owned by Paracelsus of Germany and the Australian Ramsey Group.

25. In addition, there is some evidence of regional networks being built up by health and medical service providers in Asia. For example, by the mid-1990s, the Singapore-based Parkway Group Healthcare Pte. had acquired eleven hospitals, ten in Asia and one in Britain, and a majority share in a dental surgery chain operating throughout South-East Asia.

26. The trade and developmental impacts associated with movement of health professionals may be discussed from various perspectives, focusing either on the receiving or the originating country. Relevant issues include, on the one hand, the contribution of immigration to filling supply gaps and/or reducing cost pressures and, on the other hand, the economic losses, temporary or permanent, associated with trained specialists seeking employment abroad ("brain drain").[14] For example, partly as a result of migration to the United States and Canada, 50 per cent of the posts for registered nurses and 30 per cent of midwifery posts in Jamaica reportedly remained unfilled in 1995.[15] While it has been estimated that 56 per cent of all migrating physicians are from developing countries, the destinations are not exclusively industrialized countries. For example, a significant number of Indian doctors and nurses have found (temporary) employment in the Gulf Sates and Middle Eastern

[12]Specialities reportedly include cardiovascular and ophthalmological surgery, treatment of pigmentary retinopathy and vitiligo, orthopaedics, substance abuse rehabilitation, anti-stress therapies, and cosmetic surgery. See WHO Task Force on Health Economics (1997).

[13]The following observations are based on information contained in: U.S. International Trade Commission (USITC, 1998), *Recent Trends in U.S. Services Trade*, Washington D.C.; U.S. Department of Commerce/International Trade Administration (1998), *U.S. Industry & Trade Outlook '98*. Washington D.C.; and Warner, David C. (1998), *The globalization of medical care*, in Zarrilli, S., and C. Kinnon op cit.

[14]The following information is taken mainly from WHO Task Force on Health Economics (1997).

[15]The attendant losses of human capital would need to be set against potential gains in terms of migrant workers acquiring skills and expertise which, on return, may benefit the home country or of savings and remittances that may be invested back home. In addition, it is difficult to verify whether the alternative to emigration would have been employment in the health sector or, in the event of more lucrative job offers, in another domestic industry.

countries. And some developing countries register both significant outflows and inflows of medical staff; Jamaica, for example, is said to import nurses from Myanmar, Nigeria and Ghana.

27. Available sources also indicate a growing of number small-scale hospitals with Chinese participation being opened in Asia, the Middle East, and CIS Republics. In more than 100 joint ventures (1995), the Chinese side normally provides technology and labour while the local partner contributes buildings and equipment.

Possible issues for discussion:

- *The impact of trade liberalization on the quality and availability of health services in developing countries.*

- *The impact of liberalization on the supply of health services and on health care costs in developed countries.*

- *How real are the risks for developing countries associated with the migration of qualified personnel abroad:*
  What are the likely effects on the domestic provision of health services?
  What are the wider developmental implications?
  Is there a need for policy intervention in (a) the originating and/or (b) the receiving country? What measures might be taken? Could they pose problems under the GATS and, if so, might Article XIV provide legal cover?

- *Is there evidence of trade distorting export promotion strategies aimed at diverting international demand for medical and hospital services? If so, what remedies would be available under the GATS?*

III. REGULATORY STRUCTURE AND RESULTING TRADE EFFECTS

A. GENERAL CONSIDERATIONS

28. Health services are normally provided in an environment significantly different from the textbook ideal of a market economy. A host of imperfections, distortions and information problems may prevent consumers and producers from contracting on an equal basis, in full knowledge of, and financial responsibility for, the ensuing results. For example, since there is not normally a direct relationship between the cost of medical treatment and an individual's contribution – reflecting basic equity considerations – supply tends to fall short of demand. However large a country's hospital capacity, it is likely to be filled. What observers have called Say's Law for Hospital Beds, describing the fact that additional supply tends to induce additional demand, may turn into a Health Minister's nightmare.

29. In the same vein, additional competition does not necessarily entail quality and/or efficiency gains for all population segments and interested groups. For example, private health insurers competing for members may engage in some form of "cream skimming" leaving the basic public system, often funded through the general budget, with low-income and high-risk members. New private clinics may well be able to attract qualified staff from public hospitals without, however, offering the same range of services to the same population groups. The combination of free education with lucrative remuneration of professionals may encourage "over-production" of qualified medical staff, distort the structure of human capital formation and, given generally rigid price and wage structures, boost health care costs.

Box I: Overview of Policy Initiatives to Contain Health-Care Spending

PRICE AND/OR MARKET-ORIENTED
Measures promoting competition between insurance funds (e.g. through abolition of exclusivity rights, enhanced mobility of insured persons, flexibility to modify policy conditions).
Co-payments by patients (pharmaceuticals, hospital spending, etc.).
No-claim rebates for insurance premiums.
Measures encouraging prescription or dispensation of cheaper alternatives (generally generics) in lieu of brand-name products.
Sales of pharmaceuticals through alternative distribution channels (doctors, hospitals, mail order).
Removal of products and services from reimbursement.
Creation of larger purchasing entities with market power (health commissions, etc.).
Incentives to substitute home care for hospital nursing, in particular for older patients.

PRICE AND/OR BUDGET CONTROLS
Various forms of price approval, price setting, etc. for prescription drugs, hospital and doctor's fees.
Price effectiveness as an approval criteria for new pharmaceuticals.

ORGANIZATIONAL CHANGES
Reorganization of the hospital sector (e.g. creation of larger units and improved coordination/specialization).
Exclusivity arrangements between insurers and hospitals/practices.

RESTRICTIONS ON SUPPLY OR DEMAND
Negative/positive lists for pharmaceuticals.
"Good practice" recommendations for medical treatment.
Measures to discourage direct access to specialist doctors (generalist as "gatekeepers").
Introduction of supply quotas (e.g. bed-day limits).
Caps on reimbursements (per patient, practice or clinic).
Caps on staffing (e.g. number of doctors or nurses per hospital bed).
Access restrictions for new practices, hospitals and pharmacies.

OTHERS
Legal changes influencing the waiting period for, and level of, wage compensation of sick employees.

Source: WTO Secretariat.

30. These examples do not argue against market-based reforms. However, they may indicate the potential for misallocation in a sector that often operates at the borderline between public and private sphere and is subject to a variety of – not necessarily compatible – objectives. The challenge facing health authorities is to define a consistent set of policy goals and, consequently, create a regulatory framework encouraging efficient resource use in pursuit of these goals. The relevant framework may need to evolve over time, taking into account, for example, changing policy priorities and the emergence of new communication technologies that may gradually undermine geographical barriers to information, coordination and competition.

B. CURRENT INSTITUTIONAL ARRANGEMENTS

31. There are various institutional approaches to structuring the health care sector and defining the scope for cooperation and competition between individual units. The diversity of current regimes, with otherwise similar countries opting for different systems and sometimes moving in different directions, suggests that there is no magic formula: "Designing the rules under which people can buy health care … is a deep and subtle issue of economics, ethics, and politics. The right answer almost certainly varies from country to country and from time to time."[16]. Whatever the answer, it is likely to

[16]Aaron, Henry (1996), *Thinking about health care finance: Some propositions*, in OECD, Health Care Reform op cit.

affect access conditions for health care providers as well as for related goods and services industries, in particular pharmaceuticals and insurance.

32. While there may be many variants and combinations, it is possible to distinguish three principle approaches normally used in the OECD area and, possibly, economically advanced developing countries:[17]

(i) Under reimbursement systems, patients have wide scope for selecting and contracting their preferred health care providers (doctors, hospitals, etc.). The services are paid for retroactively by the patient, who in turn is reimbursed by his insurer, or directly by the insurer. The reimbursement approach is normally used in countries with multiple insurers and multiple (often private) suppliers, including the United States, Japan and Switzerland. Closer contractual relationships and effective cost controls may prove difficult to introduce in such systems, but consumer sovereignty (freedom of choice) is generally well respected.

(ii) Contract systems involve some form of prospective agreement establishing the terms and conditions of cooperation between third-party payers and specified health care providers. Insurers tend to have greater control over both the level and distribution of funding than under a reimbursement system. Contract systems are widespread in countries where compulsory insurance is provided by a limited number of public or non-profit agencies. Hospitals are usually funded on the basis of per diem rates or fees per case or service; they may be subject to budget caps (Germany and Belgium). Consumer choice tends to be confined to a pre-selected range of hospitals, but some systems also allow for treatment by additional providers under reimbursement conditions.

(iii) In integrated health systems, one single institution fully controls the provision of health services. Medical personnel are paid salaries and other spending tends to be bulk-funded. This avoids the cost uncertainties and contractual complexities associated with other systems; however, innovation, flexibility and consumer choice may suffer. Integrated systems are used in the Nordic countries and Turkey (for general practitioners as well as hospitals) and - for public hospital services - in France, Italy Australia, Greece, Iceland, and Portugal.[18] Recent changes in the United Kingdom and New Zealand have favoured contractual approaches, while the public systems in Spain and Italy are said to have moved in the opposite direction. [19]

33. A study for the OECD area notes that, overall, the organization of health care has converged in recent years towards contract-based systems. The study emphasizes the importance of separating purchasers from providers, preferably combined with a significant degree of vertical integration, and increasing the scope for performance-based reimbursement.[20]

34. Gradual shifts towards systems with private participation may offer interesting business prospects. In this context, a recent publication by the U.S. Department of Commerce points out an increasing trend in Latin American countries, in particular Chile and Brazil, and Central and Eastern Europe (Czech Republic, Hungary and Poland) to decentralize and/or commercialize the health sector in a bid to contain cost pressures.[21] Some countries have preferred to retain the public insurance

[17]For a more detailed discussion see OECD (1995).

[18]Reports suggest that private hospitals are integrated in the Italian national health system; 90 per cent of the beds in these hospitals may be used for patients covered by the system. (Panorama of EU Industry, 1997)

[19]Jönsson, Bengt (1997), *Government Financing and Social Insurance*, paper presented at a World Bank-sponsored conference on "Innovations in Health Care Financing", Washington D.C.

[20]Jönsson, Bengt (1996), *Making Sense of Health Care Reform*, in OECD, Health Care Reform op cit.

[21]U.S. Department of Commerce/International Trade Administration (1998).

monopoly but allow for competition between private and public health care providers. Other countries have started introducing competition between integrated systems. Models recently discussed in Argentina and Colombia allow for competition between health care providers and insurance companies, with the latter being partly funded through wage taxes and direct budget transfers.[22]

Possible issues for discussion:

- *How can WTO Members ensure that ongoing reforms in national health systems are mutually supportive and, whenever relevant, market-based?*

- *Given the breadth and depth of these reforms, would it be helpful to provide a forum in the WTO to exchange information, regardless of the existence of specific commitments at present?*

C. RELEVANT DISCIPLINES UNDER THE GATS (OTHER THAN PART III)

35. As indicated above, the provision of health services, even in the most "liberal" systems, is subject to a significant degree of regulatory intervention. Measures may be targeted at the individual health care providers (doctors, physiotherapists, nurses, midwives, etc.), companies and organizations operating in the system (clinics, hospitals, nursing homes) as well as in commercially related sectors (suppliers of medical equipment and pharmaceuticals, insurance funds, etc.). These measures, and the underlying policy intentions, may be extremely diverse. For example, professional licensing requirements may be used to ensure the qualification and personnel integrity of a doctor, regulate access to the profession for cost-related reasons, protect current incumbents from new entrants (domestic and/or foreign), or ensure an adequate distribution of supply across the country and/or social groups. There is hardly any measure governing the organization of the sector or the provision of individual services that would not affect, directly or indirectly, access conditions under one of the four modes covered by the GATS.

36. To facilitate the interpretation of current commitments scheduled by WTO Members (Section IV), the following discussion focuses on measures not directly reflected in limitations under Articles XVI and XVII.[23]

Disciplines related to the organization of the health sector

37. The institutional arrangements governing the provision of health, medical and social services may vary widely, from complete government ownership and control to full market orientation. On the one hand, there is the possibility of services being provided "in the exercise of governmental authority", meaning, according to Article I:3.(c) of the GATS, that they are supplied neither on a commercial basis nor in competition. A case in point of such activities - not covered by the GATS - is the provision of medical and hospital treatment directly through the government, free of charge. In contrast, other systems may allow for full private participation without access controls, apart from quality- and qualification-related regulation, at freely negotiated prices. (Price negotiations may

[22]Jönsson (1997).

[23]Measures falling under Article XVI of the GATS typically include quota restrictions or economic needs tests used to regulate the number of hospital beds, doctors, nurses, etc. Measures subject to scheduling under Article XVII may include nationality requirements as well as any other measure which, while not falling under Article XVI, adversely affects the competitive conditions of foreign services or service suppliers. A case in point is the non-coverage of health services consumed abroad by certain public insurance schemes.

In non-scheduled sectors Members are free to operate any measure, regardless of restrictiveness, as long as a set of basic requirements is respected, including in particular most-favoured-nation treatment and certain information and consultation obligations.

involve the sector in general, with representatives of the medical professions and hospital owners/operators confronting the health insurers.)

38. Such prototypical arrangements are likely to be the exception rather than the rule. For example, although a country may guarantee free treatment in government-owned hospitals, there may nevertheless be scope for private activities unless these are prohibited *per se*.[24] In particular, private hospitals may offer non-conventional alternatives to "traditional" treatment, capitalize on bottlenecks in the public system, or provide special services for a wealthy clientele. The co-existence of private and public hospitals may raise questions, however, concerning their competitive relationship and the applicability of the GATS: in particular, can public hospitals nevertheless be deemed to fall under Article I:3? Those holding this view may argue that public hospitals (and their services) constitute a sector distinct from, and not in competition with, private hospitals (and their services). Given the perceived advantages of private over public hospitals - the absence of waiting periods, use of modern equipment, etc. - the two groups might not be considered to provide "like" services.

39. The hospital sector in many countries, however, is made up of government- and privately-owned entities which both operate on a commercial basis, charging the patient or his insurance for the treatment provided. Supplementary subsidies may be granted for social, regional and similar policy purposes. It seems unrealistic in such cases to argue for continued application of Article 1:3 and/or maintain that no competitive relationship exists between the two groups of suppliers or services. In scheduled sectors, this suggests that subsidies and any similar economic benefits conferred on one group would be subject to the national treatment obligation under Article XVII.

40. In addition, there may be various types of direct private/public-sector cooperation, for example with private companies operating public health facilities. Under so-called Build-Operate-Transfer (BOT) arrangements, governments may invite private investors to build hospitals through offering them certain exclusivity rights on a temporary basis. The legal status of such arrangements under the GATS may vary, depending on the rights and obligations conferred in individual cases. BOT arrangements, for example, may be viewed as some form of government-regulated commercial activity or as government procurement of the services involved. In the former case, for example, the authorities would be required to extend MFN treatment under Article II and – in scheduled sectors – to ensure that the relevant access criteria are "objective and transparent" (Article VI:4).[25] In the latter case, Article XIII of the GATS would provide legal cover against infringements of MFN, Market Access and National Treatment obligations.

41. The situation may be somewhat different for the 25 Member economies currently covered by the Agreement on Government Procurement (GPA). Actual application of the relevant rules, committing signatories to non-discrimination among each other if a purchase exceeds certain threshold values, is closely circumscribed. Covered are only those procuring entities and categories of goods and services that are included in Member-specific Annexes to the GPA. BOT-type arrangements may involve a variety of different services, possibly including architectural, construction and real estate services. Health and medical services as such have been included by only one Member, the United States, in the relevant Annex.[26]

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[24]It is difficult to see the rationale of such prohibitions, except possibly for cases where distributive equity and/or the public hospitals' exclusive access to scarce resources (e.g. doctors) are the dominant policy objective.

[25]Other relevant provisions may include Article VIII:2 of the GATS which obliges Members to ensure that monopoly positions are not abused in areas outside the scope of the monopoly; the supplier concerned must be prevented from acting in a manner inconsistent with the Member's specific commitments. (BOT arrangements may be considered to confer temporary monopoly rights, at least on a regional basis, on individual suppliers.)

[26]Given the predominantly private structure of this sector in the U.S., the inclusion under GPA may be considered as less economically important than it might have been for other Members which provide for a greater measure of direct government participation. For a more detailed discussion of the issues potentially

Regulatory arrangements and recognition problems

42. Three types of regulation seem to be particular relevant as they may directly affect supply or demand of medical and health services. These are, first, qualification and licensing requirements for individual health professionals; second, approval requirements for institutional suppliers such as clinics or hospitals; and, third, rules and practices governing reimbursement under mandatory (public or private) insurance schemes. While such rules and requirements may have restrictive effects on services trade, they may be covered by the relevant provisions of Article VI and, as domestic regulatory measures, not be reflected in schedules. (Article VI provides, *inter alia*, that the measures be administered in a "reasonable, objective and impartial manner" and not be "more burdensome than necessary to ensure the quality of the service"). Since health-related quality criteria may differ significantly between individual activities, Members' scope for operating qualification and licensing requirements under these provisions would need to be assessed case-by-case. For example, it might be argued that a university degree or a comparable level of education must be a precondition for certain health professionals, for instance those entitled to issue prescriptions, but not for others.[27] Value judgements may come into play as well. A society's expectations concerning the "quality of a service" are likely to be influenced by income, history and culture.

43. Recognition measures applying to foreign licences, qualifications or standards (including for medical and hospital treatment) may determine the economic value of commitments under the GATS. Such measures could affect insurance portability (thus determining the ability of patients to consume foreign hospital services) or the possibility for professionals of working abroad without undergoing additional tests and examinations. Recognition measures may gain prominence in future as the gradual opening of health insurance and health care markets in certain regions, such as Latin America, tends to enhance the regulatory conditions for trade, including via improved cross-border mobility of patients.

44. At professional level, there are various initiatives aimed at harmonizing education and certification standards. Cases in point are a Trilateral Initiative for North American Nursing, involving groups from Canada, Mexico and the United States, and efforts in Central, South and Eastern Africa towards establishing common standards and competencies for nursing.[28]

45. Recognition measures may involve a risk of discrimination and distortion to the detriment of third parties. However, such measures are subject, *inter alia*, to the disciplines of Article VII:3, which requires Members not to accord recognition in a manner which would constitute a means of discrimination or a disguised restriction on trade. Yet it may prove more difficult for affected countries to furnish proof of such infringements than in cases of outright discrimination.[29] Although a

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involved in government procurement of services, see the relevant Secretariat Note S/WPGR/W/3 of 8 November 1995.

[27]The sector description contained in CPC already implies certain basic qualification requirements. For example, general medical services (CPC 93121) as well as specialized medical services (CPC 93122) are defined, respectively, to comprise "services consisting in the prevention, diagnosis and treatment by doctors of medicine of … diseases" and "diagnosis and treatment services by doctors of medicine of diseases of a specific nature …". By contrast, dental services consist of "diagnosis and treatment services affecting the patient's teeth …"; and no reference is made to the qualification of the professionals involved. The same is true for veterinary services.

[28]See Oulton, Judith A. (1998), *International trade and the nursing profession*, in Zarrilli, S., and C. Kinnon op cit.

[29]Consider the following two scenarios: (i) Health insurers in country A are legally required to recognize treatment in a specified group of other countries for reimbursement purposes; and (ii) A's insurance legislation stipulates general hospital standards equivalent to those in B on which basis A's insurers recognize, or are required to recognize, treatment in B. It appears that in the first case, A's law is in direct contravention of, and could be challenged under, Article II of the GATS. In the second case, it may prove more difficult for an adversely affected Member to obtain a ruling requiring changes. The Member may first request consultations under Article VII:2 in order to demonstrate that its standards should be recognized as well. If these

number of recognition measures may exist in health-related areas, autonomously or through mutual agreement, the Council for Trade Services has received only one notification under the relevant provisions of Article VII:4. (The notification, S/C/N15, essentially concerns Macau's recognition of professional qualifications obtained from Portuguese institutions.)

46. The co-existence in Member economies of diverging regulatory regimes may prove a further source of friction. Institutional arrangements may determine the applicability of GATS provisions, including Article II, in individual cases. These provisions apply only to measures affecting services trade that have been taken by governments or non-governmental bodies in the exercise of delegated powers. This suggests, for example, that arrangements between private market participants – e.g. reimbursement conditions negotiated between insurance companies and hospitals – are not covered in principle, while similar conditions involving government-mandated insurers and private hospitals -or private insurers and exclusive hospital operators - would be within the remit of the Agreement.[30] However, Article IX establishes consultation and information requirements which may be invoked in the event of private market participants engaging in practices that restrain competition and thereby restrict trade.

47. Rules and practices in "regulated areas" may be used to, or have the effect of, distorting "open markets": public hospitals may be required not to accept insurance cover from foreign-based companies or a regulated domestic insurer may be prevented from reimbursing the cost of treatment abroad. Such concerns seem vindicated by significant disparities in the level of commitments undertaken by WTO Members in relevant areas. For example, of the 59 Members that have committed on medical or hospital services, 19 have not committed on health insurance services. Conversely, of the 76 Members with commitments on health insurance services, 35 have not committed on medical or hospital services (Table 3). However, Article VIII protects the rights of (potentially) affected suppliers, requiring Members to ensure that their monopoly or exclusive suppliers do not act inconsistently with obligations under Article II and specific commitments.

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consultations remain inconclusive, action may be taken under Article VII:3. In this context, the Member would need to show that recognition had been granted "in a manner which would constitute a means of discrimination ... or a disguised restriction on trade".

[30]For example, a consortium of San Antonio hospitals recently signed contracts with the four largest Mexican health insurers recognizing these hospitals as preferred providers eligible to receive patients (Warner, 1998). In the absence of further information, it appears that these were entirely private arrangements.

Box 2: The European Union – Towards an Internal Market for Health Care Services?

In many areas, the EU Single Market process may be considered a test case for wider international integration. It may give an idea of the economic benefits and rewards, but also of the problems and challenges, associated with multilateral liberalization. In health care services, the Union's experience has not been unequivocally encouraging to date. Cross-border investment is hampered by diverging institutional structures, limiting the scope for private market participation, while labour mobility may suffer from cultural and language barriers. On the positive side, however, there are recent rulings by the European Court of Justice which may enhance consumer mobility across national borders (between Member Sates) and, by the same token, limit the ability of national insurance regulators to segment demand for health care services.

The organization of the hospital sector is said to "largely reflect national regulatory environments and national heritage". While some Member States rely predominantly on public infrastructure, owned and operated by governments, others have increasingly provided room for private hospitals, clinics, day centres and nursing home facilities. At present, while private hospitals account for the majority of hospital beds in the Netherlands (mostly owned by non-profit organizations) and about 30 per cent in Greece, their share in Denmark is estimated at 0.5 per cent.

There is a large body of EU legislation intended to ensure free movement of health service professionals, including nurses for general care, based essentially on mutual recognition of professional qualifications. In the event of significant disparities, the receiving Member States may require the professional concerned to perform additional tests or undergo an adaptation period. Cultural differences (language) may also inhibit migration. Serious shortages of nurses in some Member States have not yet led to significant migration.

In two rulings given on 28 April 1998 (Kohll and Decker) the European Court of Justice outlawed national authorization requirements governing purchases of medical goods (spectacles) and consumption of medical services (dental treatment) in other Member States. The latter case revolved around a decision by the social security medical supervisors in Luxembourg who had declined to extend insurance cover to treatment sought in Germany. On the one hand, the ruling underscored that, in the absence of Community harmonization, it was for the individual Member States to determine membership conditions in their social security schemes and the conditions for entitlement to benefits. On the other hand, however, the Court held that the authorization requirement operated in Luxembourg constituted a barrier to the freedom to provide services, guaranteed in Articles 59 and 60 of the EC Treaty, which was not objectively justified. In this context, the Court also discussed, and denied, the existence of conflicting public health requirements, including the need to provide a balanced medical service accessible to all.

The ruling may have significant implications for several national insurance regimes. For example, press reports suggest that Germany's basic health insurance funds (Gesetzliche Krankenkassen) are also legally prevented from contributing to the cost of dental treatment provided abroad (situation in March 1998).

An additional ECJ ruling, also bound to affect national insurance regulation, concerned a mandatory care insurance scheme (Pflegeversicherung) introduced in Germany in 1995. The scheme is intended to ensure the provision of home care, nursing home and hospital care. Home care may be provided directly through authorized bodies or through persons/bodies to be selected by the beneficiary who then receives a monthly allowance. Financial cover is also granted for some related expenses. Any person insured in Germany against sickness – including cross-border commuters from other Member States – must contribute to the system, whose benefits, however, remain limited to persons residing in Germany. The ECJ was requested to decide on whether the asymmetry implied was compatible with relevant EC Treaty provisions, including those concerning the free movement of workers. The Court's verdict confirmed Member States' right to subject foreign residents working on their territory to mandatory social security schemes, but required that any ensuing cash benefits also be granted regardless of residency status.

Source: WTO Secretariat based on *Panorama of EU Industry* (1997), Judgments of the European Court of Justice (Cases C-120/95, 158/96 and 160/96) and *Zeitschrift des Bundesverbandes der Betriebskrankenkassen*, No. 3/98.

Possible issues for discussion:

- *With the gradual opening of a number of health care and health insurance markets, how can recognition problems be prevented from frustrating the expected gains in market access?*

- *Is it necessary in this context to distinguish between recognition measures related to:*
  (a) the quality of treatment as such (prime concern: compliance with minimum standards in terms of equipment, training of staff, hygiene, etc.) and
  (b) a provider's qualification for reimbursement (prime concern: cost effectiveness or protection of established suppliers)?

- *Would it be helpful to define priority areas for discussion and/or future work (e.g. international portability of insurance entitlements, recognition of professional and/or of hospital standards)?*

- *How can national administrations be encouraged to focus more closely on possible links - complementarities as well inconsistencies - between ongoing regulatory developments in the health care and the health insurance sectors?*

- *Are the officials involved in regulating and reorganizing these sectors sufficiently informed of existing commitments under the GATS? Are they aware of the possibility of capitalizing on market-oriented reforms in future services negotiations?*

- *Do Members see a need to encourage notification of existing or impending recognition agreements of quality standards, licences, etc. under Article VII:4 of the GATS?*

- *Article VII:5 calls on Members to extend recognition on multilaterally agreed criteria and, in appropriate cases, work towards the establishment of common international standards. Is there need for action under these provisions?*

IV. CURRENT COMMITMENTS UNDER THE GATS

A. MARKET ACCESS AND NATIONAL TREATMENT OBLIGATIONS

48. For the purposes of this Note, it appears preferable to discuss the commitments applying to modes 1 to 3 - cross-border supply, consumption abroad and commercial presence - separately from the commitments for mode 4 governing the presence of (foreign) national persons. While Members' scheduling practices in the former areas tend to reflect technical and economic specificities of the activities covered, most entries with regard to mode 4 simply extend existing horizontal commitments and restrictions. This does not imply that there are no sector-specific effects, but – as argued below – that those effects are likely to ensue predominantly from the economic objectives and constraints governing production and trade in the sector rather than from scheduling *per se*.

49. As in other services areas, it is necessary to add a note of caution: schedules do not necessarily provide an accurate, let alone comprehensive, picture of actual trade and market conditions. The fact that a Member has not (fully) committed on a sector may be ascribed to a range of policy considerations, for example ongoing domestic reforms that have not yet sufficiently materialized or lack of negotiating interest on the part of trading partners. This implies that, in the absence of additional information, non-commitments (or the scheduling of strict limitations) must not be equated with limited or non-existent access opportunities.

(a) Commitments for Modes 1, 2 and 3

50. Members generally found it easier to make commitments on health-related professional services (medical and veterinary services, etc.) than on "genuine" health and social services classified as Sector 8 in the Sectoral Classification List. While 49 Members have undertaken commitments on Medical and Dental Services, only 39 Members have committed on Hospital Services. Moreover, it is interesting to note that within the two broad groups of medical and health-related services, the level of commitments seems to be positively related to the capital and/or human-capital intensity of the activities concerned. Medical and Dental Services as well as Hospital Services have drawn significantly more commitments than, for example, Services Provided by Midwives, Nurses etc. (CPC 93191) or Social Services (CPC 933).

51. A closer look at Table 4 also reveals that many developing countries, including least developed countries, have made wide ranging commitments for various health and medical services. A large majority of the Members with full commitments across modes 1 to 3 – without exclusions from sectoral coverage or any limitations on market access and national treatment – are developing countries. On the one hand, they may have seen the scheduling process as an opportunity to create, and lock in, stable market conditions with a view to attracting foreign health care providers and, in particular, their skills and expertise. On the other hand, some of these countries may have found it easier, in terms of domestic policy pressure, to commit on areas where large-scale inflows are unlikely to occur, given the absence of attractive commercial opportunities.

52. The interpretation of the entries for mode 1 is subject to an element of uncertainty related to the question of cross-border tradability. For example, of the 39 Members that have committed on Hospital Services, 11 have undertaken full bindings for mode 1 ("none"), while 27 have not undertaken any commitments ("unbound"). Of these, 13 Members felt, according to their schedules, that cross-border supply was not technically feasible. [31]

53. In the Scheduling Guidelines developed for scheduling purposes under the GATS, Members are called upon to use such entries (i.e. "unbound due to lack of technical feasibility") whenever relevant. In the event of misjudgement or future technical change, these entries continue to mean "unbound". If a Member had failed to commit because of a misperception of what is technically possible, its schedule would look more restrictive than it was intended to be.[32] For example, among the 13 countries which indicated that cross-border trade in hospital services was not technically feasible, three (Bolivia, Panama, and Swaziland) assumed full commitments under modes 2 and 3. This might indicate that these Members, and possibly some more, had undertaken commitments for mode 1 as well, had they felt that cross-border supply was possible.[33]

54. Few Members have limited consumption abroad (Mode 2) of the medical, health and dental services covered by this Note. This may come as a surprise, as governments may be tempted to constrain their nationals' ability to consume such services abroad: for example, they may consider it too difficult to prevent waste and abuse and/or may not want to confront national suppliers, already hit by cost-cutting initiatives, with further income losses. (Poland and Bulgaria have made limitations

[31]In the United Nations Provisional Central Product Classification, CPC 9311 - Hospital Services - is defined as covering "Services delivered under the direction of medical doctors chiefly to in-patients, aimed at curing, reactivating and/or maintaining the health status of a patient. Hospital services comprise medical and paramedical services, nursing services, laboratory and technical services including radiological and anaesthesiological services, etc.". It may be worth noting that this definition does not require the simultaneous physical presence of both doctor and patient.

[32]In turn, this implies that in Table 4 the third column ("unbound") under Cross-border supply is artificially inflated and gives too negative an impression of Members' actual policy stance.

[33]A further example is New Zealand which, while 17 Members undertook full bindings for cross-border supply of veterinary services, made no commitments on the grounds of technical non-feasibility. On the other hand, New Zealand committed, without limitation, access under modes 2 and 3.

concerning the non-coverage by public medical insurance schemes of services provided abroad.)[34] On the other hand, consumer movement may prove a partial substitute for the movement of personnel (mode 4, see below), help contain the adverse cost effects, in high wage countries, of protected domestic labour markets, and be viewed as a "safety valve" in systems that cannot ensure immediate treatment domestically.[35]

55. By contrast, limitations on market access and/or national treatment are far more frequent under mode 3, commercial presence. This applies in particular to Medical and Dental Services, Hospital Services and Social Services. The limitations are intended to provide cover, *inter alia*, for economic needs tests intended to contain health costs, nationality requirements, equity ceilings, joint venture requirements and not further specified licensing and approval procedures. The picture for Social Services is strongly influenced by the Members of the European Union which were among the relatively few countries to undertake commitments on these services at all; however, given the existence of sector-specific exclusions from coverage, these commitments are recorded as "limited" in Table 4.

56. As noted in another Background Note (Legal Services, S/C/W/43), the scheduling of licensing requirements and procedures is somewhat surprising. If licensing is intended to implement restrictions affecting market access or national treatment, it is these restrictions that would need to be scheduled. Otherwise, if the relevant requirements and procedures as such do not comply with GATS provisions, they would need to be brought into conformity. Scheduling would not exempt them from compliance, for example, with Article VI.

Possible issue for discussion:

- *To improve clarity and comparability of schedules, would it be helpful to develop a common understanding among Members of the activities and circumstances in which trade is not technically feasible?*

(b) Commitments for Mode 4

57. As in other areas, the level of mode-4 commitments, governing the presence of national persons, trails far behind the commitments undertaken for the three other modes.

58. Among the 55 Members that have committed on medical, dental and/or veterinary services, whether for the entire sector or sub-classes, only two countries, Guinea and Haiti, have not made any limitations for mode 4.[36] Five Members have not undertaken any commitments for that mode, 32 have maintained horizontal limitations, and 16 have scheduled sector-specific entries. In the latter context, 12 Members have further narrowed existing horizontal commitments; most frequently, they have added nationality and/or residency requirements.

59. In evaluating the economic effects of such limitations, it is worth bearing in mind the sectoral environment within which they apply. The impact of "standard" horizontal entries is far from being uniform, but may vary significantly across sectors. Such variations are likely to depend in particular on the prevailing mode(s) of supply, the factor-intensity of production (e.g. its human capital and basic labour requirements) and the degree to which foreign personnel is able to substitute for nationals. In the latter context, factors such as professional expertise or language may play a role.

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[34]The partial commitments recorded for mode 2 in Table 4 mainly reflect exclusions of specified sub-segments from full sectoral coverage.

[35]For example, in Norway, a waiting-list system covers 40 per cent of all patients. They are classified according to three levels of priority with those at the highest level being guaranteed treatment within no more than six months. (According to the Norwegian Minister of Health; see OECD, 1996.)

[36]The picture for health related and social services is largely similar.

60. It appears reasonable to assume that for many medical, health and social services, mode 4 restrictions are particularly significant. This is based mainly on three observations: (i) the scope for other modes of supply, especially cross-border trade and consumption abroad, tends to be limited; (ii) the activities concerned are generally labour and/or human capital intensive and, in a similar vein, (iii) while commercial presence may be highly relevant in some sectors, the most significant benefits from trade are unlikely to arise from the construction and operation of hospitals, etc., but their staffing with more skilled, more efficient and/or less costly personnel than might be available on the domestic labour market.

(c) Additional considerations

61. As discussed before, trade in medical, health and social services is strongly influenced by measures not normally considered to be "trade measures". These may include (i) licensing and qualification requirements designed to ascertain the quality of the services provided and the integrity of professionals; (ii) restrictions on the range of goods and services professionals and hospitals are allowed to provide[37]; (iii) controls or incentives intended to ensure the adequate provision of services in all regions and for all population groups; and (iv) the direct provision, on social policy grounds, of minimum services to economically disadvantaged groups.

62. Despite their restrictive or discriminatory (side-)effects, views may differ among Members whether these measures would need to be scheduled in all cases.

Possible issues for discussion:

- *Article XVII covers all measures that modify the "conditions of competition" to the detriment of foreign suppliers of like services. Does the Article also apply to potentially discriminatory measures, such as language requirements, which may be necessary to ensure the quality of certain services, including those provided by general practitioners?*[38]

- *Exclusions from public insurance schemes of treatment predominantly provided by foreign specialists (e.g. herbal medicine): problems under Articles II, XVI and VII?*

- *The status of regional policy interventions under the GATS: in what circumstances is it necessary to schedule measures discouraging access to overcrowded regional markets, regional branching requirements, etc?*

- *How do Members interpret the criteria contained in Article I:3 (services supplied neither on a commercial basis nor in competition): Would the levying of a charge or the existence of private hospitals preclude cover?*

(d) MFN exemptions

63. Among the MFN exemptions listed by WTO members in the context of the Uruguay Round or recent accessions, eight cases relate to professional services in general – thus extending to the four categories covered by this Note – or to individual health and social services. The exemptions have been listed by Bulgaria, Costa Rica, Cyprus, Dominican Republic, Honduras; Panama, Turkey and Venezuela. In a clear majority of cases, the intended purpose is to provide legal cover for some type of reciprocity requirement governing market access for professionals (Table 5). In one case (Cyprus), it is not possible to identify the precise nature of the MFN problem expected to be covered. In

[37]Typical examples are "positive" or "negative lists" of goods and activities, which may have been issued for budgetary reasons.

[38]Iceland has scheduled under Article XVII a language requirement for veterinaries.

another case (Bulgaria), the description of the measure seems to indicate that consumers rather than suppliers of health and medical services are subject to an element of discrimination.

V. INTERNATIONAL ASSOCIATIONS AND OTHER SOURCES OF INFORMATION

64. Given time and resource constraints, this presentation is necessarily impressionistic in nature. It may be criticized by health policy experts for over-emphasizing trade and commercial policy objectives and not paying sufficient attention to fundamental equity and other social policy considerations essential to the work of national and international organizations in the sector. The purpose of the Note, however, was to provide background information on economic and regulatory factors governing trade in health and social services, including commitments under the GATS, rather than presenting and analysing the full range of objectives and constraints policy makers may be confronted with. Interested delegations may find such material in recent publications issued, separately or jointly, by WHO and UNCTAD experts or in relevant studies by the World Bank and OECD. A starting point could be a 1997 Technical Briefing Note prepared by the WHO Task Force on Health Economics (op cit.) and supplementary literature referred to in this Note.

ANNEX

RELEVANT TERMS AND DEFINITIONS

Division 93 of the United Nations provisional Central Product Classification (CPC) is designed to cover all health and social services, including services provided by professionals (doctors etc.) in practices. Division 93 forms part of larger Section 9, which is devoted to Community, Social and Personal Services. This structure differs somewhat from the sectoral pattern underlying the Sectoral Classification List (MTN.GNS/W/120), on which most Members have based their schedules. The Classification List's definition of Health Related and Social Services does not cover medical and dental services; veterinary services; and services provided by midwives, nurses, etc. The latter three categories figure under Professional Services which, in turn, are a sub-sector within Business Services (Table A1).

The distinction in the Sectoral Classification List between, on the one hand, Health-Related and Social Services and, on the other hand, Medical and Dental Services depends mainly on whether the relevant activities include some type of institutional nursing. For example, while hospital services are understood to be destined "chiefly" for in-patients, services provided by out-patient clinics are considered to fall under Medical or Dental Services. However, a similar distinction has not been made for veterinary services and social services. All veterinary services, regardless of whether they are provided in hospitals or not, are grouped under Professional Services, while all social services, including those provided without accommodation, figure under Health Related and Social Services.

Given the multitude of individual functions that may be performed by a doctor, veterinary, clinic or social institution, it is not surprising that this classification (and, possibly, any alternative) gives rise to questions:

(i) Would boarding kennels be considered to fall under Veterinary Services?
The answer is likely to be negative, since veterinary services are defined in CPC as being aimed at "curing, reactivating and/or maintaining the health status of the animal". In contrast, Services Incidental to Agriculture (CPC 8811) are defined to include "animal boarding, care and breeding services".
There appears to be an element of confusion, however, resulting from the United Nations International Standard Industry Classification; in ISIC, Rev. 3, boarding kennels are defined as veterinary services (ISIC 8520). At the same time, the relevant Correspondence Table between ISIC and CPC establishes full concordance between the Health and Social Services industry, covered by ISIC 85, and the relevant product definition in CPC (CPC 93).

(ii) Can treatment on "beauty farms" or plastic and similar types of surgery be classified as medical or hospital services? Again, the crucial question seems to be whether such activities may contribute to "curing, reactivating and/or maintaining" a patient's health or otherwise be health related. What, however, if a service is provided mainly for aesthetic purposes? Could it nevertheless be considered to constitute some form of health or medical treatment and, thus, be captured by CPC 9319 and, consequently, category 8.D in the Sectoral Classification List?[39]

[39]One possibility is to classify such services as "residential health facilities services other than hospital services" (CPC 93193). These services are defined in CPC to cover combined lodging and medical services not carried out under the supervision of a medical doctor located on the premises. Would this class also cover services provided without any medical supervision?

Austria has specified in its schedule that commitments on CPC 93193 include health resort hotels and therapeutic bath services.

(iii) What is the intended coverage of "Other" Health Related and Social Services (category 8.D) in the Sectoral Classification List? Given that the definition of the preceding health and social services categories is non-exhaustive, it is difficult to see the need for a residual group.[40] (While no Member has committed separately on these services, two Members have undertaken commitments across the full range of Health Related and Social Services, thereby including 8.D.)
By the same token, it is possible that the – not further specified – "other" category under Professional Services (1.A.k.) covers some medical or similar services as well. In the absence of further information, it remains unclear whether the two Members that have undertaken full commitments on these "other" services, intended to include health-related activities.

Possible questions:

- *Scheduling techniques: What categories in the Sectoral Classification List do Members consider to cover:*
  (i) non-medical services for animals (including kennels) and
  (ii) medical services for humans (e.g. plastic surgery for aesthetic reasons) which are not primarily health-related or intended to prevent, diagnose and treat diseases?

- *Do Members see a need, for the sake of clarity and transparency, to specify the coverage of those "other" categories in the Sectoral Classification List that have no CPC equivalents?*

[40]As already mentioned, CPC 9319 covers human health services not elsewhere classified, while 93319 and 93329 are intended to cover "other" social services provided either with or without accommodation.

Table A1: Health and Social Services in the GATS Scheduling Guidelines and CPC

Sectoral Classification List	Relevant CPC No.	Definition/coverage in provisional CPC
1. BUSINESS SERVICES		
A. Professional Services		
[…]		
h. Medical and dental services	9312	Services chiefly aimed at preventing, diagnosing and treating illness through consultation by individual patients without institutional nursing…
i. Veterinary Services	932	Veterinary services for pet animals and animals other than pets (hospital and non-hospital medical, surgical and dental services).
j. Services provided by midwives, nurses, physio-therapists and paramedical personnel	93191	Services such as supervision during pregnancy and childbirth … nursing (without admission) care, advice and prevention for patients at home.
k. Other [a]	n.a.	n.a.
8. HEALTH RELATED AND SOCIAL SERVICES		
A. Hospital Services	9311	Services delivered under the direction of medical doctors chiefly to in-patients aimed at curing, reactivating and/or maintaining the health status…
B. Other Human Health Services	9319 (other than 93191)	Ambulance Services; Residential health facilities services other than hospital services; Other human health services n.e.c.[b]
C. Social Services	933	Social services with accommodation;[c] social services without accommodation[d]
D. Other	n.a.	n.a.

n.a. Not available

a Relates to all professional services (including sub-sectors (a) to (g)).

b Services in the field of : morphological or chemical pathology, bacteriology, virology, immunology, etc., and services not elsewhere classified, such as blood collection services.

c Welfare services delivered through residential institutions to old persons and the handicapped (PPC 93311) and children and other clients (93312); other social services with accommodation (93319).

d Child day-care services including day-care services for the handicapped (93321); guidance and counselling services n.e.c. related to children (93322); welfare services not delivered through residential institutions (93323); vocational rehabilitation services (excluding services where the education component is predominant) (93324); other social services without accommodation (CPC 93329).

Table 1: Health Care Expenditure in OECD Countries, 1970-1992
(Per cent of GDP)

	1970	1975	1980	1985	1990	1991	1992
Australia	5.7	7.5	7.3	7.7	8.2	8.5	8.8
Austria	5.4	5.3	7.9	8.1	8.4	8.6	8.8
Belgium	4.1	5.9	6.6	7.4	7.6	8.1	8.2
Canada	7.1	7.2	7.4	8.5	9.4	10.0	10.3
Denmark	6.1	6.5	6.8	6.3	6.3	6.6	6.5
Finland	5.7	6.4	6.5	7.3	8.0	9.1	9.4
France	5.8	7.0	7.6	8.5	8.9	9.1	9.4
Germany	5.9	8.1	8.4	8.7	8.3	8.4	8.7
Greece	4.0	4.1	4.3	4.8	5.3	5.3	5.4
Iceland	5.2	6.2	6.4	7.0	8.2	8.4	8.5
Ireland	5.6	8.0	9.2	8.2	7.0	7.6	7.1
Italy	5.2	6.1	6.9	7.0	8.1	8.6	8.5
Japan	4.6	5.6	6.6	6.5	6.6	6.7	6.9
Luxembourg	4.1	5.6	6.8	6.8	7.2	7.3	7.4
Netherlands	6.0	7.6	8.0	6.0	8.2	8.4	8.6
New Zealand	5.2	6.7	7.2	6.5	7.3	7.7	7.5
Norway	5.0	6.7	6.6	6.4	7.5	8.0	8.3
Portugal	3.1	6.4	5.8	7.0	5.4	5.9	6.0
Spain	3.7	4.8	5.6	6.7	6.6	6.5	7.0
Sweden	7.2	7.8	9.4	8.9	8.6	8.5	7.9
Switzerland	5.2	7.0	7.3	8.1	8.4	9.0	9.5
Turkey	-	3.5	4.0	2.8	4.0	4.7	4.1
United Kingdom	4.5	5.5	5.8	6.0	6.2	6.6	7.1
United States	7.4	8.4	9.2	10.5	12.4	13.4	14.0

Source: OECD, (1995).

Table 2: Basic Health Indicators for Different Country Groupings

COUNTRIES	HEALTH EXPENDITURE (1990-95)		PHYSICIANS	HOSPITAL BEDS	LIFE EXPECTANCY AT BIRTH	
	% of GDP	Per capita (US$)	Per 1000 people (1994)		1980	1996
Low income	4.2	22	1.0	1.6	58	63
(excl. China and India)	(3.1)	(18)	(0.4)	(1.5)	(51)	(56)
Middle income	5.1	209	1.6	4.6	63	68
Low and middle income	4.5	83	1.2	2.7	60	65
East Asia & Pacific	3.6	27	1.4	2.1	65	68
South Asia	5.0	21	0.4	0.7	54	62
Middle East & North Africa	4.5	433	n.a.	1.8	59	67
Sub Saharan Africa	2.9	55	n.a.	1.2	48	52
Latin America & Caribbean	6.7	248	1.4	n.a.	65	70
Europe & Central Asia	5.4	138	3.1	9.1	68	68
High income	9.6	2,404	2.5	7.4	74	77

n.a. Not available.

Source: World Bank, *World Development Indicators 1998*, Washington, D.C.

Table 3: Summary of Specific Commitments on Medical, Health-Related, Social, and Health Insurance Services

Members	Professional Services			Health-Related and Social Services				Health Insurance
	Medical and Dental Services	Veteri-nary Services	Nurses, Midwives etc.	Hospital Services	Other Human Health S.	Social Services	Other	
Antigua and Barbuda	x							
Argentina								x
Aruba								x
Australia	x	x			x			x
Austria	x	x	x	x	x	x		
Bahrain								x
Barbados	x							
Belize	x				x			
Bolivia				x				x
Botswana	x	x	x					
Brazil								x
Brunei Darussalam	x							x
Bulgaria	x	x				x		
Burundi	x	x		x	x			
Canada								x
Chile								x
Colombia								x
Congo RP	x	x						
Costa Rica	x			x				
Cuba								x
Cyprus								x
Czech Republic	x	x						
Dominican Republic	x			x	x	x		x
Ecuador				x				x
Egypt								x
EC (12)	x	x	x	x		x		x
Finland		x	x					
Gabon								x
Gambia	x	x	x	x	x	x		x
Ghana								x
Guinea		x					x	
Guyana	x							x
Haiti		x						
Honduras								x
Hong Kong, China								x
Hungary	x			x	x	x	x	x
Iceland		x						x
India				x				
Indonesia								x
Israel								x
Jamaica	x		x	x				x
Japan				x				x
Kenya								x
Korea, Rep. of								x
Kuwait				x	x	x		
Lesotho	x	x	x					x
Liechtenstein								x
Macau								x
Malawi	x		x	x	x			
Malaysia	x			x				x
Malta								x

Members	Professional Services			Health-Related and Social Services				Health Insurance
	Medical and Dental Services	Veteri-nary Services	Nurses, Midwives etc.	Hospital Services	Other Human Health S.	Social Services	Other	
Mauritius								x
Mexico	x		x	x	x			x
Morocco								x
New Zealand		x						x
Nicaragua								x
Nigeria								x
Norway	x	x	x					x
Pakistan	x			x				x
Panama				x				x
Paraguay								x
Peru								x
Philippines								x
Poland	x	x	x	x				x
Qatar	x	x						x
Romania								x
Rwanda	x							
Saint Lucia				x				
Senegal	x							x
Saint Vincent and the Grenadines				x				
Sierra Leone	x	x	x	x	x	x	x	x
Singapore	x	x						x
Slovak Republic	x	x						x
Slovenia	x			x	x			x
Solomon Islands								x
South Africa	x	x	x					x
Sri Lanka								x
Swaziland	x			x				
Sweden	x	x	x					x
Switzerland	x	x						x
Thailand								x
Trinidad and Tobago	x	x		x				
Tunisia								x
Turkey				x				x
United Arab Emirates		x						
USA				x				x
Venezuela								x
Zambia	x		x	x	x			
TOTAL	49	37	26	39	13	19	3	76

Note: EU Member States are counted individually.

Source: WTO Secretariat.

Table 4: Overview of Commitments for Modes 1,2 and 3 on Medical, Health-Related and Social Services (Number of Members)

Sector	Number of Members *(Full commitment for Modes 1-3)*[a]	Cross border supply (Mode 1)			Consumption abroad (Mode 2)			Commercial presence (Mode 3)		
		Full[a]	Limited	Unbound	Full[a]	Limited	Unbound	Full[a]	Limited	Unbound
Medical and Dental services	49 *(12)*[b]	17	6	26	38	7	4	19	24	6
Veterinary services	37 *(10)*[c]	17	2	18	33	1	3	19	14	4
Midwives, nurses, etc.	26 *(4)*[d]	6	4	16	21	5	0	10	16	0
Other (incl. medical serv.)	3 *(1)*[e]	2	1	0	2	1	0	1	2	0
Hospital services	39 *(9)*[f]	11	1	27	31	5	3	18	17	4
Other human. health services	13 *(6)*[g]	6	1	6	6	5	2	8	4	1
Social services	19 *(2)*[h]	3	0	16	4	13	2	5	13	1
Other health and social serv.	3 *(2)*[i]	2	1	0	2	1	0	2	1	0

a Full commitments for both market access and national treatment and no limitations in sectoral coverage.

b Brunei Darussalam, Burundi, Congo, Gambia (subject to horizontal limitations for mode 3), Guinea, Hungary, Iceland (subject to language requirement), Malawi, Norway, Rwanda, South Africa; Zambia.

c Australia, Burundi, Congo, Finland, Gambia (subject to horizontal limitations for mode 3), Lesotho, Qatar, Singapore, South Africa, Saudi Arabia (subject to horizontal limitations for mode 3).

d Gambia (subject to horizontal limitations for mode 3), Malawi, Norway, Zambia.

e Iceland.

f Burundi, Ecuador, Gambia (subject to horizontal limitations for mode 3), Hungary, Jamaica, Malawi , Saint Lucia, Sierra Leone, Zambia.

g Burundi, Gambia (subject to horizontal limitations for mode 3), Hungary, Malawi, Sierra Leone, Zambia.

h Gambia (subject to horizontal limitations for mode 3), Hungary, Sierra Leone.

i Hungary, Sierra Leone.

Source: WTO Secretariat.

Table 5: MFN exemptions applying to professional services in general and/or specified medical, health or social services

Country and sector	Measure	Countries covered
BULGARIA Medical and dental services	Benefits under public medical insurance, subsidization and compensation schemes covering medical and dental services are extended to foreigners staying in Bulgaria on the basis of reciprocity.	Current and future signatories to bilateral agreements
COSTA RICA Professional services	Foreign professionals may become members of professional colleges only if a reciprocal agreement with the home country exists and/or in certain cases if Costa Ricans may exercise the profession in similar circumstances in the country concerned.	All countries
CYPRUS Human health services and social security	Human health services: Measures governing the provision to Cypriots of medical treatment not otherwise available in Cyprus. Public social security: Measures covered by bilateral agreements on social security.	All countries with whom medical co-operation might be desirable (agreements currently exist with medical centres in Greece, United Kingdom and Israel). Austria, Canada (Quebec) and any country with whom an agreement may be concluded in future.
DOMINICAN REPUBLIC Dental, physiotherapy, medical, paramedical and nursing services	Dentists, physiotherapists, doctors, paramedical personnel and nurses may exercise their profession only on the basis of reciprocity.	All countries
HONDURAS Professional services	Authorization to exercise a profession is granted on the basis of reciprocity.	All countries
PANAMA Professional services	Authorization to exercise a profession is granted on the basis of reciprocity.	All countries
TURKEY Professional services	Possibility of prohibiting the supply of services in Turkey if the supplier's home country maintains legal and administrative conditions adversely affecting Turkish citizens who supply similar services.	All countries
VENEZUELA Professional services	Laws governing the supply of professional services by foreigners (including physicians and veterinary surgeons) may specify as a condition that Venezuelans must receive the same treatment in the applicant's home country.	All countries

Source: WTO Secretariat based on documents GATS/EL/122, 22, 25, 28, 38, 124, 88 and 92.