UNCTAD-WHO Joint Publication
International Trade in Health Services
A Development Perspective
Geneva, 1998

[Doc. symbol: UNCTAD/ITCD/TSB/5 - WHO/TFHE/98.1]

9. GATS COMMITMENTS IN THE HEALTH SERVICES SECTOR AND THE SCOPE FOR FUTURE NEGOTIATIONS

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I. INTRODUCTION

The health economy is a conglomeration of activities encompassing delivery of goods and services, whether through public or private provision. The main purpose and outcome of an efficiently functioning health economy are the improved health of the population, by ensuring universal access to adequate health care. International trade in health services could facilitate the fulfilment of this task, and developing countries could benefit from growing trade in health services by being aware of the opportunities available to them. These include import of specialized medical skills that might be in short supply locally, development of intrahospital trade aimed at minimizing operational costs, use of teleprocesses as inputs and also as final services or products in delivery of medical care.

This paper reviews specific commitments in health services negotiated in the World Trade Organization (WTO) as an integral part of the General Agreement on Trade in Services (GATS). Stocktaking in this respect is imperative before future rounds of negotiations in this sector can proceed.

The analysis of commitments does not provide a full picture of the actual trade regime in health services. Furthermore, some of the important players in the health services market have not made any specific commitments in the sector. The commitments in health services made by most countries have had no policy implications so far, since countries have either recorded the *status quo* of their trade regimes, provided partial information, or left sensitive aspects out of their schedules of commitments. However, future rounds of multilateral negotiations are likely to come closer to exerting pressure for changes in the trade regime by seeking a higher degree of openness in specific areas of commitments in health services. Awareness of what issues are involved and contribution to the conduct of negotiations by public health officials would help achieve sustainable levels of commitments and maximize benefits accruing to the general public as a result of the liberalization of trade in health services.

Although health insurance, hospital management, management consulting, etc. are not classified explicitly under the health services sector, these and other relevant aspects in delivery of health care would have to be taken into account when seeking to further liberalize trade regimes in the health services sector.

II FRAMEWORK FOR THE MULTILATERAL TRADE NEGOTIATIONS IN HEALTH SERVICES

Negotiations on trade in services in the GATS framework have covered a number of services sectors, health services being only one - and not particularly important - sector from the negotiators' point of view. With the successful completion of the recent negotiations on trade in financial, and basic telecommunication services, however, progressive liberalization of trade in services is expected to expand into other services sectors. Health services are characterized as a dynamic market in many developed and some developing countries. Their export and import flows are not limited to regional trade where otherwise pertinent issues can be dealt with, though regional trade is particularly important in this area. For the United States major export markets are not only its partners in NAFTA[1] but included Germany, Japan, Saudi Arabia, Spain, Switzerland, and the United Kingdom[2]. Thus, health services are very likely to become one of the issues in the future multilateral trade negotiations. The review of what has been achieved so far should serve as a point of departure.

As the outcome of negotiations on services during the Uruguay Round, countries have deposited with WTO their schedules of commitments on trade in services, which are an integral part of GATS, which entered into force in 1995. The unique scheduling structure in GATS differentiates measures[3] into those that affect all sectors, so-called horizontal commitments[4], i.e. investment, taxation, immigration laws, etc., and those that affect specific sectors. Discussion in this paper will be limited to sector-specific measures. No attempt will be made at intercountry comparison of the level of commitments in the health sector since overriding limitations on market access and national

[1] The North American Free Trade Area is established between Canada, Mexico and the United States.

[2] USITC investigation 332-358, 'General Agreement on Trade in Services: An examination of Major Trading Partners' Schedules of Commitments'. Publication No. 2940, 1995.

[3] According to the definition provided in GATS, measures could include laws, regulations, rules, decisions, administrative actions, other forms of measures.

[4] Discussion of some aspects of the horizontal commitments is provided in documents UNCTAD/SDD/SER/7 and TD/B/CN.4/43.

treatment could be imposed through the horizontal commitments. The aim is simply to identify what specific measures are included as limitations on the trade in health services *per se*, and to see what could constitute a limitation to market access or national treatment in this sector, that might become a focus in future multilateral negotiations.

Scope of the health care services

Health care services include the general and specialized services of medical doctors, deliveries and related services, nursing services, physiotherapeutic and paramedical services, all hospital services, ambulance services, residential health facilities services and services provided by medical and dental laboratories. In the multilateral negotiations, professional services of doctors and nurses were distinguished from those of hospital services and have been negotiated separately[5].

These services could be delivered by private medical establishments or public ones. With respect to the GATS commitments, services provided privately and those provided by public medical institutions on a commercial basis or in competition with other providers would be subject to the specific commitments. The export of services by public health establishments from Australia or India as a way to raise foreign currency is a good example of how public medical institutions operate on a commercial basis.

Modes of supply

GATS has established that trade in services takes place through four modes of supply which are discussed at length in chapter 1. These modes of supply for health services are of different relative importance. Notably, consumption abroad and establishment of facilities are leading the trade in health services at present.

Cross-border supply seemed technically not feasible for some countries at the time of conclusion of the GATS negotiations, but rapid development in technology is bringing many changes and hopes for the future of telemedicine. Due to the nature of new technologies, it would be difficult to imagine that individual countries would impose restrictions on this type of trade, but issues of standards, liability and recognition of qualifications would have a limiting effect on its further development.

Consumption abroad plays a significant role in health services, which is characteristic of very few services sectors. When foreign patients come to receive treatment, which equals export of services for the medical-care providing

[5] A services sectoral classification has been adopted in GATS which corresponds broadly to the United Nations Central Product Classification (UN CPC). UN CPC version 1 has been completed and submitted for publication recently.

country, it is mostly viewed favourably in this country, unless these services are subsidized or nationals find themselves at a disadvantage in a dual system. If these issues begin to place increasing pressure on public finances or on the public health care system in general, changes in internal rules, regulations and policies might improve the functioning of the health care system. The development of specialized tourism related to health care holds great promise for a number of developing countries. Lack of portability of insurance will probably remain the only effective formal barrier to trade through this mode of supply.

Commercial presence or establishment, when foreign investors acquire or establish a medical treatment facility, the supply of services through the medical establishment amounts to import of medical services. Most countries are interested in attracting foreign investment but, owing to the inherent social nature of the health services, investment in medical facilities is often subject to supplementary regulations and requirements in addition to those laid down in the national laws on investment. These measures would be of primary interest during the multilateral negotiations, and would eventually be included in the schedules of specific commitments, either partially or in full.

Movement of natural persons, i.e. movement of medical professionals, is rather limited at present, since migration laws lack sufficient flexibility to allow for trade-related temporary entry of natural persons. Trade in health services through this mode of supply is further complicated by the lack of recognition of qualifications and experience. Since these limitations are not restricted only to the medical professionals, they are included in the horizontal commitments. Further liberalization of trade in this area could call for a new approach to negotiations on the movement of natural persons in general, and development of the overall multilateral framework agreement for the temporary movement of natural persons.

Types of commitments

Particular terminology has been adopted in the GATS schedules of specific commitments. Commitments are made with respect to each mode of supply and fall into the categories described below.

Full commitments: imply no discriminatory restrictions to market access and full national treatment of the foreign services and service providers. This is the ideal maximum that trade liberalization can aim to achieve, i.e. inclusion of the word ‘none’ next to every mode of supply in the schedule of specific commitments. To a large extent this has been achieved for the selected modes and services sectors. However, the relative significance of the modes of supply varies depending on the type of services sector. Information provided in the health services regarding the establishment of firms and health professionals is

the most pertinent in improving transparency in the trade regime since these are the principal ways of trade in health services.

No commitment: modes are left out of schedules and no information is provided. Equally, countries can opt to include all modes of supply in the schedule of commitments, but still provide no information by stating that the mode remains 'unbound'. In this case, countries remain free to introduce any new measures regulating foreign service provision in the relevant segment of the domestic market. In the next round of negotiations, inclusion of any information, including for transparency purposes, will improve these commitments qualitatively.

Partial commitments: information is provided, implying that the mode in a sector is 'bound'. When commitments are 'bound' in this way, measures listed will not become more restrictive in the future. Often the information provided is not exhaustive but would already improve the transparency of the trade regime and could serve as a benchmark for future liberalization.

Statistics on trade in services

Statistical data does not allow measurement of the volume of trade through each of these modes[6]. Selected statistical data would be indispensable, however, in preparation for future negotiations on services and would serve in identifying own country needs. Furthermore, in the review of the economic integration agreements in accordance with GATS Article V, countries are required to demonstrate the substantial sectoral coverage of such liberalizing agreements, which should be measured in terms of volume of trade and modes of supply[7]. Additional requirements for national services trade statistics arise during the Trade Policy Review exercise and in the event of modification of the schedule of commitments.

To further the establishment of relevant national databases on trade in services, the conduct of regular surveys could initially bridge the gap between the needs of the trade negotiators and the statistics that are currently available. Such surveys, in addition to obtaining the relevant statistical data on trends and patterns of trade, may seek to obtain facts on the main problems faced by private operators in their services export markets.

[6] Comprehensive data on trade in health services particularly, in accordance with WTO needs, is not yet readily available. In the IMF balance of payments statistics, labour income is not broken down by sector, medical fees paid abroad are included in living expenses there, and a gap exists in estimating the relative share of foreign investment in the selected services sector. The best available data would be some aggregate of the health services sector as a whole. In addition, data comparability could suffer depending on the country definition of the particular services sector.

[7] No preferential trade agreements deal explicitly with health-related services, except the measures adopted by the European Commission.

Some relevant provisions in GATS

The key concept in GATS is most favoured nation (MFN) treatment which implies that the trade measures defined in the schedule of specific commitments apply to all WTO Members, unless specific exemptions to this provision were made in the individual country schedule[8]. A total of six countries[9] made MFN exemptions with respect to professional services, thus covering the services of medical doctors, nurses and paramedical personnel, while two of them noted health professionals specifically. MFN exemption would imply that better treatment would be accorded to service operators of all or selected countries based on the following criteria: *reciprocity* requirement, when treatment of foreign health professionals would correspond to that received by national health professionals in those countries; and *bilateral agreements* defining the medical services provision and limiting it to the countries which are parties to the agreement.

The other single most important discipline that could have a tremendous positive impact on growth in trade in services is the requirement of transparency in the trade regime. However, developing countries, particularly those which are only introducing the necessary legislation on services, would have a significantly simpler, and thus more transparent, regime than those, usually developed countries, which have a comprehensive and complex services trade regime already in place. Other things being equal, those two types of country would have different conditions for market access.

Another important obligation for the GATS signatories is to achieve objectivity and impartiality in the regulatory environment for services. Laws and other legislative measures should not favour domestically supplied services and would need to be amended if this requirement is not met, unless it is explicitly included in the specific commitments. If the provision of health services is formally limited to a small number of suppliers or is supplied exclusively by one, a government, for example, or if subsidies are used as part of health care provision, there is no requirement in GATS to change the type of system. The major condition is not to establish exclusive service providers or any other new measures, formally or in effect restricting trade in health services, for those aspects where GATS commitments have been undertaken[10].

[8] So-called Article II (MFN) Exemptions, attached to the schedules of specific commitments. In principle, no extension of the MFN exemptions to include health services would be possible in the future.

[9] Costa Rica, Cyprus, Dominican Republic, Honduras, Turkey, Venezuela.

[10] GATS provides for the renegotiation of the schedule of commitments and withdrawal of commitments; however, no precedents in this respect have occurred so far.

Key issues for the facilitation of trade in professional health services would be the development of multilaterally agreed criteria for the recognition of qualifications. Work could proceed in this direction at the regional level, or be promoted by the international professional associations, as in accountancy services. Since establishment of multilateral standards is a long-term objective, GATS stipulates that at present any agreement on mutual recognition of qualifications[11] should be open-ended for accession by any other interested WTO Member.

A total of 59 countries, that is, close to half WTO Member countries, have included one or more aspects of health services in their GATS schedules of specific commitments. Regional distribution of the commitments is shown in the table 1 below.

[11] The example of such agreement is the recently concluded Agreement on Mutual Recognition between the United States and the European Union.

Table 1. **Distribution of commitments by region**

Service sector[12]	Total	Developed countries[13]	Africa	Latin America	Asia	Central, Eastern Europe
Medical and dental services	48	17	10	9	6	6
Services provided by midwives, nurses, physiotherapists and paramedical personnel	23	15	5	2	0	1
Hospital services	37	15	4	10	5	3
Other human health services	10	2	3	2	1	2

Before turning to the analysis of specific commitments on health services, it is worth mentioning here that the commitments made under insurance services could be particularly important in negotiating trade liberalization in health services, since the lack of portability of insurance could substantially impair trade in health services. In some ways, the commitments providing access to telecommunication networks could either facilitate or preclude cross-border trade in health services.

III SERVICES PROVIDED BY MEDICAL PROFESSIONALS: ANALYSIS OF COMMITMENTS

A summary of commitments in the relevant sectors provided in the following tables demonstrates vividly the present state of play. For reasons of simplicity, tables do not show that three countries have made more limited commitments regarding doctors' services and two regarding other medical professionals, by specifying in greater detail the definition of the services sector[14]. Scope of commitments in terms of the number of countries that have

[12] The classification follows that adopted in GATS.

[13] Commitments of the European Communities are counted as 12 or less depending on the number of member countries that have undertaken commitments under the relevant modes of supply. In this table EU commitments are counted as 12, except that no commitments were scheduled for 'other' services.

[14] This does not contradict the letter of GATS, since the GATS classification itself has no official status.

included these two categories of professional services in their schedules of specific commitments is quite limited and future negotiations would seek to expand this number. Very few countries have made commitments on services provided by medical personnel other than medical or dental doctors. Even those developing countries that have well-established comparative advantage in their export of nursing services, or those developed countries that *de facto* have a liberal regime for import of medical services, have not made any commitments under those two categories of medical services. This could be attributed partly to the fact that in many countries medical services are not supplied and consumed as part of market-based services. In addition, this particular type of service is very closely linked to the movement of natural persons and could have raised concern among others on this score. Even investment in this area of trade is closely linked to some type of movement of professionals providing services.

Cross-border trade

A somewhat lesser degree of openness in commitments is apparent for cross-border trade when compared to consumption abroad. Uncertainty and difficulty in defining what would fall under this type of trade might have been a contributing factor to the more cautious approach. Technical advances will definitely open the debate on liberalizing trade through this mode of supply. At present, an important part of cross-border trade is intrafirm trade via teleprocesses. They include consultations, pre- and postsurgery follow up, certain medical testing performed abroad, etc. Note that cross-border trade often follows the establishment of foreign affiliates since companies develop contacts through them

Table 2. **Cross-border trade**

Service sector	Market access			National treatment	
	Unbound	None	Measures	Unbound	None
Medical and dental services	20	16	1 no portability of insurance	24	13
Services provided by midwives, nurses, physiotherapists and paramedical personnel	5	6	1 no portability of insurance	5	7

Consumption abroad

Basically, consumption abroad has been fully liberalized. The expected increase in trade through the movement of consumers to purchase medical

services abroad for the countries that have made commitments already would not come from the more open or transparent trade regime but through other changes, such as in domestic social and cultural factors, new domestic and foreign business practices, including marketing, etc. Other most significant measures limiting the purchase of health services abroad would be portability of insurance which could be addressed, if necessary, in the context of negotiations on health insurance services.

Table 3. **Consumption abroad**

Service sector	Market access			National treatment	
	Unbound	None	Measures	Unbound	None
Medical and dental services	2	34 (1 no portability of insurance)	1 no portability of insurance	4	33
Services provided by midwives, nurses, physiotherapists and paramedical personnel	0.00	11	1 no portability of insurance	0.00	12

Commercial presence

The status of commitments concerning commercial presence would show if foreign service providers could supply services to the local market through establishment of facilities. Free trade would mean that medical professionals would be able to open a medical or dental clinic, or an office abroad. However, actually to practice the profession themselves, not considering the separate issue of whether employment of local staff is permitted, their medical credentials would have to be recognized. Different procedures may involve licensing or registration, the requirement of membership of professional associations, or other requirements. These measures do not constitute a barrier to market access *per se*, if applied in a nondiscriminatory manner, mandated under the GATS in domestic regulation. However, effectively they could restrict services trade partially or totally. Trade through establishment of facilities in medical professional services is closely linked to the movement of natural persons. Thus commitments would not really be trade enhancing if corresponding market opening and national treatment were not provided with respect to both establishment and movement of service providers.

Countries have devoted most of their efforts to scheduling their commitments against the commercial presence mode, since the main flow of international service trade concerning medical professionals would be expected to take this form. More commitments are of a partial nature, providing information only with respect to selected aspects of market access. The difference is more pronounced in the more cautious treatment of foreign service providers under market access as compared to their national treatment. Willingness to provide more equitable treatment for those foreign service providers already established in the market is expressed in the higher share of full commitments to nondiscrimination under national treatment, i.e. ‘none’ of

the discriminating measures applied. Having less experience in services trade and being 'under the veil of ignorance' with respect to the consequences on their economic development and national capacity building, most countries were relatively careful in undertaking liberal commitments in market access.

Table 4. **Commercial presence**

Service sector	Market access				National treatment			
	Total	Unbound	None	Measures	Total	Unbound	None	Measures
Medical and dental services	43	4	18	21	48	5	37	6
Services provided by midwives, nurses, physiotherapists and paramedical personnel	22	0	8	14	23	0	22	1

Only one case had an explicit reference to the law governing market access and national treatment. In this respect, no precise inference could be made as to the actual trade regime in this particular service sector. The conditions listed under **market access** most frequently require foreign medical professionals to provide services as natural persons, i.e. relate to conditions defined in the mode of movement of natural persons, which is discussed below. Often conditionality to provide medical services as natural persons is followed by the requirement of authorization by the relevant health authority, which according to the letter of GATS, is the domain of domestic regulation. The same applies for the licensing, registration or need-to-pass examination conditions, and membership of professional associations. The justification for inclusion of these conditions under market access would suggest their application in a trade-restrictive manner. If, however, this is not the case, their inclusion provides additional transparency as to the procedures which exist in the country. The economic needs test[15] included in the five market access commitments for medical and dental doctors could be interpreted as a limitation on the total number of natural persons who may provide medical services. Due to its discretionary nature, the economic needs test is one of the most trade-distorting measures, since it means that market access can be declined or granted, provided that certain conditions are met, as determined by the designated authority.

[15]The economic needs requirement poses a major barrier to trade, since it leaves space for discretion in regulating market access, based on the subjectively defined criteria, which in turn could be quantitative or qualitative.

Few countries included pharmacy services in their schedules of commitments under the medical services other than doctors. This is not clearly apparent from the classification adopted in GATS or the UN CPC, but is not in contradiction to the spirit of these classifications, as discussed earlier. This set of commitments indicated the existing monopoly for pharmacies and the economic needs test for market access, providing information about the criteria for its application.

GATS does not impose any restrictions on the type of ownership[16], but monopoly or exclusive service providers have to be included in the schedule of specific commitments, if such is the domestic market structure in those sectors where commitments are being undertaken[17]. Subsidy is not yet strictly defined in GATS, although one distinction has been made in regard to access to subsidies for private practitioners. This suggests that the subsidization aspect is particularly important in medical services access and has strong social implications. However, this is an aspect that is more appropriate for consideration under the national treatment regime.

When requirement of permanent residency or nationality is listed it implies that no trade in services is allowed, since it contradicts the notion of temporary movement of service providers and equates it with their permanent establishment in the country. In a few cases limited practice has been allowed, and also a distinction has been made between the public health-care system and privately provided health services. These aspects seem to be more in the nature of national treatment. The reference to hospital services in a few of the commitments requiring joint venture, limited capital participation or partnership, should cover services provided by outpatient clinics, medical practitioner's cabinets or offices, clinics attached to firms, schools, etc., but not traditional hospital services, classified in a different category.

Movement of natural persons

A few measures included in the conditionality for **national treatment** were limited to the requirement of the knowledge[18] of the local language, employment of local staff, restricted access to private practice, and necessary additional training. A limited notion of the recognition of foreign competence has found some scope in a couple of commitments, signifying the importance of developing internationally comparable professional standards or advancing their mutual recognition for promoting trade in services.

[16] As discussed under the 'Scope of Health Services', government services fall outside the scope of GATS.

[17] Gats Article VIII deals with this aspect and emphasizes the necessity to limit the abuse of monopoly power of such suppliers outside their monopoly rights.

[18] When there is not a requirement to pass language examinations, foreign medical professionals could hire interpreters and thus comply with the language requirement.

However relevant facilitation of travel of medical professionals abroad may seem for the development of trade in medical services, this mode has not received equally prominent treatment in the schedules of commitments. General limitations to entry and definition of categories of persons admitted to WTO Member countries are listed under the cross-sectional commitments not discussed in the present paper; however, specific information regarding medical professionals was expected to be provided under these schedules. With regard to medical professionals, no exact information is provided concerning the conditions under which they could be admitted to provide their services. Limited information on the sector-specific procedures was included along with noncommitting statements of 'unbound' by a number of countries on the last mode of trade in services. This supplementary information was open to discussion, bearing in mind that no serious liberalization regarding the entry of medical personnel has been achieved so far.

Table 5. **Movement of natural persons**[19]

Service sector	Market access				National treatment			
	Total	Unbound	None	Measures	Total	Unbound	None	Measures
Medical and dental services	41	32	1	11	48	39	5	11
Services provided by midwives, nurses, physiotherapists and paramedical personnel	23	23	0	8	23	21	2	7

The majority of commitments imply that no trade is possible through this mode since the precondition included in the commitments was that of nationality or residency. Other measures included permit, authorization, registration, or membership of professional associations, i.e. similar to the measures in the commercial presence mode. These measures should be interpreted as discriminatory, since otherwise they would pertain to the domain of domestic regulation which is outside the scope of specific commitments. It should be noted, however, that one commitment registered fully open market access and granted full national treatment to medical professionals.

[19] Countries have left their commitments largely unbound for market access and many for national treatment; however, in addition some have provided complementary information which would be included in the 'measures' column.

IV OTHER COMMITMENTS IN HEALTH SERVICES, INCLUDING HOSPITAL SERVICES

Commitments on health services in this category cover medical services provided for inpatients in hospitals of various types, including rehabilitation services. Other human health services refer to ambulance services, residential health services facilities without the presence of a doctor and medical laboratories, but the list is not finite. The way these services are defined, commitments made in this sector are particularly relevant for trade through the commercial presence and establishment mode.

Distribution of the commitments under **cross-border** trade scarcely provides an insight for interpretation. However, as mentioned in one commitment, lack of technical feasibility could have been the main reason at the time. Further development and application of telemedicine and teleprocesses in general are bringing more content to the commitments in this mode of supply. The general interpretation, though, implies that medical services, provided as telemedicine consultations, testing or other relevant distance procedures, including analysis, when the patient is in hospital, fall within this category of trade in services. The difference from the preceding discussion on trade in professional medical services is that here all services are provided while the patient is in the hospital, as opposed to the outpatient treatment of the earlier cases. In addition, hospital management consulting, testing of contamination levels in the hospital, etc. which are supplied from abroad via regular or electronic/telecommunication means are also subject to commitments under this mode of supply.

Table 6. **Other commitments: cross-border trade**

Service sector	Market access		National treatment	
	Unbound	None	Unbound	None
Hospital services	16	10	13	13
Other human health services	6	4	5	5

As in the earlier discussion on **consumption abroad**, countries do not consider it feasible to control the movement of their nationals for hospital care or other like services abroad. The most effective limitation that is applicable *de facto* to the majority of potential health services consumers is the limitation on the reimbursement of their expenditure for the care obtained abroad. Thus the services purchased abroad would most probably be those that do not fall under insurance coverage in any case. The question of legal responsibility and recognition of certification of the medical establishments providing health-care abroad must be addressed before discussion on the portability of insurance can advance. These aspects are receiving increased consideration with the growing importance of telemedicine services, but so far, in the national context.

Table 7. **Other commitments: consumption abroad**

Service sector	Market access			National treatment		
	Unbound	None	Measures	Unbound	None	Measures
Hospital services	2	22	2 no portability of insurance	2	21	3 no portability of insurance
Other human health services	1	9	0.00	1	9	0.00

Commercial presence in the form of establishment of hospitals abroad is the most relevant mode to trade in these services. It is worth mentioning that hospital management services are not explicitly included in the classification definition, but play an important part in providing for a well functioning health-care facility abroad. Under **market access**, a third, i.e. 11 commitments, have reserved the right to apply the economic needs test for granting access to the new service providers. This test is based either on qualitative criteria such as the needs of the population, or a quantitative criterion such as the maximum number of beds in relation to the population or distance between hospitals. The possibility of resorting to these discretionary measures would not encourage or help to attract investment into this sector.

Only two cases have clear indications as to the laws and regulations which govern market access conditions. Other measures included are limiting the size of the foreign capital participation to varying levels of 30 per cent, 49 per cent, and 51 per cent of the ceiling, although some do not impose any limitations on its participation. Another type of market access measure requires foreign participation as a special legal entity, a requirement to meet the minimum size, or as a joint venture. The only ceiling of 49 per cent for foreign capital participation is included in respect of market access for the other medical services. The requirement to establish control of the hospital by nationals would more probably qualify as a limitation in national treatment, while authorization, permission, certification or licensing included under market access should again be interpreted as discriminatory measures, or, alternatively, as measures of domestic regulation included here probably for transparency purposes. **National treatment** is granted for foreign capital participation almost in full, with two references made to possible exclusion from subsidization, including for consumers of their services.

Table 8. **Other commitments: commercial presence**

Service sector	Market access				National treatment			
	Total	Unbound	None	Measures	Total	Unbound	None	Measures
Hospital services	32	3	12	19	37	4	31	4
Other human health services	10	0	9	1	10	1	9	0

Though hardly any liberalization has been achieved for the **movement of natural persons**, few commitments to full market access and national treatment were made anyway, as indicated in the column 'none' in the table above. Some additional requirements were, however, indicated that would be applicable for those willing to provide services to patients in hospitals. For management, authorization was necessary in one case; for all other professions, permit, nationality, permanent residency, registration and certification were needed, all of which are likely to be measures of a discriminatory nature with respect to foreign service providers. Again, the nationality and permanent residency constraint is trade precluding and contrary to the temporary nature of the movement of the services providers.

Table 9. **Other commitments: movement of natural persons**

Service sector	Market access				National treatment			
	Total	Unbound	None	Measures	Total	Unbound	None	Measures
Hospital services	37	22	2	7	37	31	7	0
Other human health services	10	10	0	1	10	10	0	1

In table 9 above, it should be noted that countries have left their commitments largely unbound for market access and for national treatment; however some have provided complementary information which would be included in the 'measures' column.

In comparison with other modes of supply, movement of services providers as natural persons did not make sufficient improvement in market access or national treatment in the health services sector. To a large extent, specific commitments with respect to the movement of natural persons have provided very limited information, even with respect to the minimum requirements that foreign natural persons would face in order to be considered

for obtaining market access. When statistical information regarding the modes of supply becomes available on a wider basis, negotiations will be able to address market access better and seek answers on how this trade takes place. Since such data will not be to hand for a long time to come, other approaches to the negotiation of commitments on movement of persons may be considered. The outcome of negotiations is the sum of rights and obligations; national service providers might gain better market access in some areas, in others, domestic market access would have to be extended to foreign services and service providers. In seeking to obtain better market access for the movement of natural persons in health services, negotiations within one service area may be difficult to pursue, and it would be better to consider a balanced approach in negotiating a number of sectors.

V CONCLUSIONS

The challenge for developing countries in future negotiations is to obtain gains in those areas where they have a comparative export advantage. The UNCTAD expert meeting on trade in health services recognized the importance of a number of issues for a positive negotiating agenda for developing countries. In this connection, public health authorities have to increase their awareness of the following key aspects of trade in health services at multilateral and other negotiating fora:

- solving of issues pertaining to the portability of health insurance would improve the available options of medical care to consumers worldwide, and would minimize to a certain degree overall costs of insurance. Development of telemedicine services, which enables prediagnosis and postsurgical follow-up to be performed, would further facilitate movement of consumers;

- negotiations in other services sectors, particularly commitments on cross-industry measures, must be taken into account, since they may offset or even nullify existing commitments in health services;

- limited liberalization has been achieved so far for the movement of suppliers of medical services. Without significant commitments in the movement of natural persons, anything included under the commitments of professional medical services would be of limited value. More attention could be devoted to establishing the link between commercial presence and the movement of service providers, since the two modes of supply are closely interdependent in the health sector. Additional issues come to mind in this respect, including the recognition of qualifications;

- aspects of the recognition of qualifications (GATS, Article VII) and of domestic regulation through issuance of licences (GATS, Article VIII) go beyond the specific commitments on trade in health services. Their implications,

however, are far reaching. If services suppliers are unable to meet the established national requirements, foreign market access will be closed to them. On the other hand, if countries wishing to import specialized medical services do not provide for the recognition of qualifications of their providers, they will create unnecessary barriers. Development of comparable legislation to facilitate the process of international recognition of qualifications of national medical personnel would create the basis for future export opportunities;

• GATS (Article V) provides an opportunity to benefit from advanced liberalization of regional services trade, which is particularly important for developing countries. For example, Egypt has become an important medical service provider in the Middle East; Cuba has established medical centres and is building new links with countries in Latin America; ethnic affinity is driving the movement of patients in Asia. Harmonization of qualifications and of other standards, as well as the removal of trade barriers in all modes of supply, would be achieved more easily at the regional level. The experience accumulated in all developing regions supports inclusion of trade in health services in the regional trade agreements;

• developing countries may seek flexibility in their commitments through better use of the provisions contained in GATS Article IV. This approach would best secure attainment of their development objectives and gradually increasing participation in international trade.

Health services have two important dimensions - the immediate function of delivering health care to the population, while contributing to economic development. The latter implies that the health economy does not have to be considered as only a burden on the public finance, but could become a net contributor, without compromising the primary objectives of health-care provision. Effective domestic policy would also have to take into consideration the multiplicity of issues discussed, not only at multilateral, but also at regional and bilateral negotiations:

• integration agreements, including the European Union, NAFTA, MERCOSUR and ASEAN, cover trade in services. Usually they are constructed on the GATS framework, but go further in terms of depth and scope of coverage. Developing countries in particular could benefit from integration agreements, including the creation of free trade areas;

• negotiations on removing trade barriers in services could proceed faster and more easily in integrated groups, where individual country interests could be taken more into consideration. Furthermore, stringent time limits could be set for the liberalization of commercial presence linked to facilitation of the movement of health service providers in the area covered by the agreement;

- a compromise solution could perhaps be found in the regional setting for such issues as portability of insurance. The experience of the European Union in this respect could well be taken into account;

- where regional trade arrangements include small-size economies, creation of a regional health-care infrastructure could increase overall efficiency. Establishment of regional specialty hospitals could improve the variety of available medical services regionally, while reducing overall costs. Creation of regional pension funds could play a similar role.

The new issues need a new trade policy regime that would also cover trade in health services. Balancing these goals is a challenge for domestic policy-makers, who have to search for innovative approaches which, at the same time, could build upon the export capacity of their national health-care systems.