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TRADE IN HEALTHCARE AND HEALTH INSURANCE SERVICES: THE GATS AS A SUPPORTING ACTOR (?)

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TRADE IN HEALTHCARE AND HEALTH INSURANCE SERVICES:
THE GATS AS A SUPPORTING ACTOR (?)

Rudolf Adlung

Abstract:

The General Agreement on Trade in Services (GATS) is broader in policy coverage than conventional trade agreements for goods and, at the same time, offers governments more flexibility, in various dimensions, to tailor their obligations to sector- or country-specific needs. An overview of existing commitments on healthcare and health insurance services shows that WTO Members have made abundant use of these possibilities.

While most participants elected not to undertake bindings on healthcare services at the end of the Uruguay Round, nor to make offers in the ongoing negotiations, insurance services have been among the most frequently committed sectors. If there is a common denominator, regardless of the Members concerned (except for recently acceded countries), it is the existence of a lot of 'water' between existing commitments and more open conditions of actual access in many sectors. This may also explain, in part, why there have been very few trade disputes under the GATS to date - far fewer than under the GATT in merchandise trade. Also, governments appear to be generally hesitant in politically and socially sensitive areas to take action in the WTO.

There are indications, however, that the same 'players' have acted differently in other policy contexts. For example, it appears that under recent preferential trade agreements (PTAs) the European Communities has been even more cautious in committing on hospital services and protecting scope for (discriminatory) subsidies than under the GATS. Yet, this is not necessarily true for the obligations assumed by many countries, including individual EC Member States, under bilateral investment treaties (BITs). These treaties overlap with the GATS, as far as commercial presence is concerned, and may be used by aggrieved investors to challenge policy restrictions in host countries. However, though frequently invoked, BITs do not meet the same standards, in terms of transparency, open (consensual) rulemaking and legal certainty, as commitments under the GATS.

JEL classification: F13, F53, F59, I18, K33

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INTRODUCTION

The impact of the General Agreement on Trade in Services (GATS) and the Doha Round negotiations on health-related policy objectives (universal access, equity, etc.) has been viewed with scepticism by quite a number of sector experts. However, very little has actually happened at the negotiating table. At the end of the Uruguay Round, in 1993/94, a strong majority of WTO Members elected not to assume any trade obligations, in terms of market access or national treatment, in relevant sectors. And there has been little change over time. Typically, medical and hospital services (healthcare[1]) are the only major areas that have remained exempted from the plurilateral request-and-offer process initiated in the wake of the Hong Kong Ministerial Conference of December 2005. For lack of negotiating interest, no group of 'proponents' or 'demandeurs' has emerged. [2]

The situation in health insurance is conspicuously different. Like other financial services, insurance services have been included frequently in WTO Members' schedules of specific commitments. This was due mainly to a 'late harvest', driven by many developed countries' active economic interests. Negotiations on all financial services - from non-life insurance to asset management - had been extended twice beyond the timeframe of the Uruguay Round to be finally concluded in late 1997. Interestingly, this was at the peak of the then Asian financial crisis. While the proponents' continued insistence certainly was a contributing factor at the time, it was also the risk of further economic destabilization, in the event of failure, that might have helped to win over sceptical governments in Asia and elsewhere. In the Doha Round, again, financial services is one of the key areas in which new or improved commitments are being sought. As before, the negotiations in this sector are shaped by economic interests, active or passive, and by regulatory/prudential concerns specific to these services.

Issues related to the particular role of health-related services, which might warrant attention in a trade policy context, have not been raised under the GATS to date. Governments seem generally aware of existing legal or definitional uncertainties and, more importantly, of the political sensitivities involved. In the absence of egregious violations of current obligations and commitments under the GATS, nobody may want to rock the boat. Yet, such hesitations may play a lesser role in another context - bilateral investment treaties (BITs) - where perceived trade and investment barriers could be challenged as well. And while the possibility exists at least to discuss and, hopefully, clarify GATS-related aspects in WTO fora, the BIT/health-interface defies multilateral scrutiny and the associated exchanges of intelligence and experience.

The following discussion is organized in six sections, starting with a brief overview of institutional arrangements governing the supply of healthcare and health insurance services in OECD countries. The second section deals with potentially relevant GATS provisions. Particular attention is given to the status of so-called 'governmental services', which may differ between healthcare and health insurance services, and its relevance in practice. The third section focuses on existing

[1] The term 'healthcare' is used in the following to denote several subsectors in the Services Sectoral Classification List MTN.GNS/W/120, which has been widely used by WTO Members whenever they undertook commitments in any of these services: medical and dental services; services provided by midwives, nurses, physiotherapists and para-medical personnel; and hospital services. In some instances, in keeping with the scheduling practice used by the European Communities, medical, dental and midwives services are referred to jointly in the following discussion. While hospital services are provided chiefly to in-patients, with a focus on curing, reactivating and/or maintaining a person's health status, medical and dental services are chiefly aimed at preventing, diagnosing and treating illnesses without institutional nursing. (In turn, these definitions are taken from the United Nations' Provisional Central Product Classification (prov. CPC) which has been generally used to clarify the scope of the sectors contained in the Services Sectoral Classification List MTN.GNS/W/120.)

[2] Annex C of the Ministerial Declaration provides that the main negotiating approach, via bilateral exchanges of requests and offers between interested delegations, be complemented by a plurilateral variant where like-minded Members form groups to pursue joint interests vis-à-vis others.

commitments under the GATS. It seeks to explain how the European Communities and the United States translated their particular institutional arrangements into 'GATS language', the possible need for modifications should these arrangements be changed, and any associated interpretation problems. A brief overview of developments in the Doha Round follows. The fifth section then discusses, from a GATS' perspective, the obligations that WTO Members have assumed in other contexts, i.e., under preferential trade agreements and investment treaties. In conclusion, the final section comments on the need for consistency between the policy obligations negotiated in different contexts.

I. THE PROVISION OF HEALTH SERVICES: BASIC PATTERNS

Depending on the underlying funding mechanisms and contractual arrangements, current health systems in OECD countries may be categorized into nine distinct groups (Chart 1). However, no existing system clearly fits into only one of these groups, and key institutional elements may change over time. Except for the United States, all systems are (almost) universal in coverage.

Among the European countries, two types of arrangements may be distinguished. One relies essentially on tax-financed integrated healthcare where virtually all citizens are treated free of charge at the point of service delivery (the 'Beveridge model' as practised in the UK, Southern European and Nordic countries); the other is based predominantly on statutory sickness funds ('Bismarckian model') which reimburse the costs of treatment either to patients (e.g., France) or directly to the healthcare providers (e.g., Germany and the Netherlands). The insurers often operate on a not-for-profit basis, and are financed via payroll deductions, employer contributions and direct government transfers.

Chart 1.
National health systems - Funding structures and service contracts

		Funding Structures		
		Private Insurance	**Statutory Sickness Funds**	**Tax-Based**
Service Contracts	**Integrated Healthcare**			
	Prospective Contracting			
	Reimbursement			

Source: Boscheck (2005).

Most people have supplemental private insurance to widen and deepen the levels of coverage. In France, this applies to about 80 per cent of the population. In Germany, participation in a public sickness fund is obligatory for over 90 per cent of the population; about 10 per cent of the fund members do have complementary private insurance. High-income earners may opt out of the fund, but are then normally insured in full by private companies. In other countries, most notably Switzerland and the Netherlands, universal coverage is provided by competing private suppliers which, especially in the case of the Netherlands, are tightly regulated and controlled. Companies exposed to higher risks are compensated out of a risk equalization fund (Netherlands); certain disadvantaged population groups may be directly subsidized.

Virtually no system covers all expenses. Patients may need to contribute their own payments, depending, for example, on their income status or the types and level/intensity of treatment. The costs of pharmaceuticals are not fully reimbursed in most cases.

The provision of health-related goods and services, whether pharmaceuticals, medical treatment or (in-patient) hospital treatment, is frequently organized separately from the insurance system. Pharmacies are predominantly privately-owned and -operated in most OECD countries, and the same is true for the sale of medical equipment and accessories. Medical and paramedical treatment, including physiotherapy and the like, is also provided in many instances by private practitioners, including in the form of cooperatives, on their own account. Hospitals may be owned and operated by public entities (municipal, regional or central governments), private non-commercial organizations (foundations, trusts, charities etc.), or profit-oriented companies, including in the form of larger hospital chains. The three types may well coexist within the same jurisdictions.[3]

A common facet of virtually all healthcare systems, including those with strong commercial elements, is intensive government regulation and control. This is normally for four reasons: to accommodate genuine health-related concerns; pursue social/distributional objectives; guard against excessive use and contain costs; and counterbalance various (other) market imperfections associated with the existence of scale economies and information asymmetries. Such considerations generally apply to the full 'supply chain', from the provision of insurance cover to sales of pharmaceuticals and medical equipment, and (out-patient) medical or (in-patient) hospital treatment. Cost and price controls may be complemented by quantitative limitations, for similar reasons (i.e., to prevent over-supplies and/or excessive treatment), on the number of newly approved practices or hospital beds that would qualify under a country's public insurance scheme. Such restrictions, applied on a regional basis, may also serve to contain supply imbalances between agglomerations and remote rural areas.[4]

II. POTENTIALLY RELEVANT GATS DISCIPLINES

A. Scope and Coverage

The public scepticism surrounding the GATS is not least rooted in the Agreement's unusually broad coverage in terms of types of transactions and associated policy obligations. Article I sets the bar quite high: The Agreement applies to government measures affecting trade in services which, in turn, is defined to cover four different modes of supply. In addition to the conventional concept of cross-border trade ('mode 1'), these include the consumption of services abroad ('mode 2'[5]) as well as the establishment of a commercial presence, normally involving foreign direct investment, and/or the presence of foreign natural persons as service professionals in a host market ('mode 3' and 'mode 4'). However, the Agreement's broad coverage and its (potential) intrusiveness, if compared to the General Agreement on Tariffs and Trade (GATT), its 60-year old counterpart in merchandise trade, is tempered by much flexibility. And this applies in several dimensions (Table 1).

Only two types of activities are explicitly exempt from the scope of the Agreement. These are, first, services that are provided in the *'exercise of governmental authority'* (Article I:3) and, second, measures affecting *air traffic rights* and directly related services (Annex on Air Transport

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[3] For example, in Germany some 50 per cent of hospitals beds are accounted for by public institutions, some 35 per cent by voluntary organizations, and the remainder by private for-profit hospitals.

[4] Note that under the GATS the status of price controls and similar forms of regulatory intervention may differ from that of formal entry restrictions. See following section.

[5] Typical examples of mode 2, from the perspective of an individual WTO Member, are cases where its nationals (or permanent residents) travel abroad to consume tourism, education or health services in another Member's jurisdiction. At first glance, the role of mode 2 may appear commercially meaningless since governments might not be able to influence the consumption of persons who have moved into a foreign jurisdiction. However, potential instruments exist; the imposition of foreign exchange restrictions, tourist visa charges or the non-extension of otherwise available consumer subsidies are cases in point. See also section III.C(i).

Services). The latter case is the only sector-specific exclusion from the GATS; it is subject to periodic review. All other services are covered. What essentially matters in theses cases is the existence of *specific commitments*. In non-committed sectors and modes, a Member does not assume any obligations with regard to two key trade-policy parameters: market access and national treatment. Their scope is specified in Articles XVI and XVII, respectively.

Table 1.
GATT vs. GATS: Main features in a nutshell

GATT	GATS
Coverage: Cross-border trade in products (goods).	Three additional modes of supply: consumption abroad, commercial presence, and presence of natural persons. (+) Related extension of core disciplines to treatment of suppliers (+) and, by implication, to behind-the-border measures. (~)
Tariffs are the only negotiable instruments of protection.*	All conceivable types of trade and investment barriers are negotiable. (<>) Absence of a commonly agreed measure of protection. (~)
Relatively strict compliance with MFN obligation, subject to one major exemption (Preferential Trade Agreements).	Additional scope for MFN departures, including in the form of 'Article II Exemptions' and recognition measures concerning foreign licences, certificates, etc. (<>)
Automatic extension of national treatment to imports.	Negotiable. Departures from national treatment, of whatever type, are not precluded per se. (<>)
International product standards are widely available as templates for domestic regulation; Members are held to use such standards.	International service standards are relatively scarce; there are no particular incentives in GATS to encourage their use. (<>) (~)
Core disciplines (concerning use of quotas, subsidies, etc.) extend to exports as well.*	No constraints on policies to promote or restrict own supplies ('exports') under the four modes. (<>)
General exceptions for overriding policy reasons (protection of life and health, public morals, public safety, etc.)	Additional exceptions for prudential measures (banking and insurance services), visa restrictions and labour-market policies; full exclusion of 'governmental services'. (<>)
Possibility of contingent protection in the event of subsidized or dumped imports or in 'safeguards situations' (sudden import surges that would cause serious injury).	No similar instruments. The 'question of emergency safeguard measures' and the 'appropriateness of countervailing measures' are covered by negotiating mandates under Articles X:1 and XV:1, respectively. (> <)

Legend:
(+) = Wider coverage than GATT; (<>) / (> <) = More / less flexibility; (~) = Less transparency
* Subject to specified exceptions for natural resource-based products.
Note: 'GATT' includes related Multilateral Agreements governing trade in goods (e.g., the Agreements on Technical Barriers to Trade and on the Application of Sanitary and Phytosanitary Measures).

Source: Based on Adlung (2009).

Each WTO Member is required under the GATS (Article XXI:1) to submit a schedule of commitments. However, sector coverage and levels of liberalization are not specified in the Agreement or any subsequent legal instruments. Even in sectors in which commitments are undertaken, Members are free in their schedules to attach limitations related to market access or national treatment under any of the four modes of supply, or even to exempt individual modes completely from coverage. Apart from inscribing such limitations, a Member may also decide to exclude potentially sensitive segments from the scope of a sector as initially defined in a non-

mandatory Classification List that has been widely employed for scheduling purposes (MTN.GNS/W/120).

At the risk of over-simplification, the granting of full market access, in the absence of limitations, may be equated with a government's guarantee not to operate or introduce any quantitative restrictions on: the number of suppliers admitted in a particular service sector; their turnover or assets; the form of legal incorporation; the participation of foreign capital; or the number of natural persons that are allowed to supply the service concerned.[6] The operation of needs tests, under which applications for new licences may be assessed, would also be inconsistent with unfettered market access and, thus, needs to be covered by a limitation. In turn, full national treatment implies a commitment not to operate any discriminatory measures that, in law or in fact, would disadvantage foreign services and their suppliers *vis-à-vis* like domestic services and/or suppliers. Discriminatory measures which call for limitations could consist, for example, of differences in tax treatment, access to subsidies, constraints on land use or ownership, etc.

The inscription of limitations and the modification of sector definitions may be used for trade-defensive purposes, but they could also serve typical social and public policy objectives. However, there is no automatic link between such objectives and the need for limitations. Depending on a country's regulatory and institutional regimes, relevant objectives might well be pursued by 'non-schedulable' types of interventions, including non-discriminatory regulatory obligations (e.g., universal service requirements[7]) or taxes and subsidies. Thus, if a government wants to ensure a reasonable regional balance in the supply of health services across the country, it may introduce access restrictions, for example in the form of a needs test, on new medical establishments (practices, hospitals, etc.) in population centres. Alternatively, it could operate tax/subsidy schemes that favour a more decentralized regional structure. While the former type of measures would need to be covered by a limitation on market access, should the relevant sector be scheduled (for actual cases, see section III.B), regional variations in taxation or subsidization would not be inconsistent *per se* with the Agreement's market access and national treatment disciplines.

The existence of access obligations does not affect a government's ability to choose whatever regulatory objectives it deems relevant in a particular sector. If there are constraints in the Agreement, these are intended essentially to prevent the commercial value of existing access obligations from being undermined, *inter alia*, by generally applicable measures that are not administered in a reasonable, objective or impartial way (Article VI:1) or by unnecessarily burdensome regulations, in pursuit of a given policy objective, that would nullify or impair the benefits of a commitment and could not reasonably have been expected at the time of its entry into force (Article VI:5). The precise scope of the latter disciplines, which for the time being offer abundant scope for regulatory intervention, is still under negotiation as part of the Doha Round.

B. The Concept of 'Governmental Services'

(i) Key Elements[8]

Pursuant to Article I:3 of the GATS, services supplied 'in the exercise of governmental authority' are exempt from the definitional scope of the Agreement. This is regardless of any additional considerations concerning ownership or legal personality of the supplier involved. Apart from a rather vague definition of the services concerned - 'any service which is supplied neither on a commercial basis nor in competition with one or more service suppliers' - the Agreement does not

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[6] For a more comprehensive explanation see, for example, Adlung and Mattoo (2008).

[7] A frequently quoted example in the area of health is a requirement for all commercial hospitals in India to treat a specified share of poor patients on a *pro bono* basis.

[8] For a more detailed discussion, with some differences in emphasis, see Krajewski (2003), VanDuzer (2004), Cossy (2005), Adlung (2006), and Leroux (2006).

provide further guidance. Terms and concepts such as 'public services' or 'services of general interest' are absent from the GATS.

In many countries, services that might be considered 'public services' are provided by suppliers that are organized on a commercial and/or competitive basis. Voice telephony or road transport are cases in point. They clearly do not fall under the GATS definition of 'governmental services'. However, what is the status of ambulance services that are provided on a cost-recovery basis by a municipal entity? Are these commercial transactions, despite the absence of profit-seeking intentions? Possibly yes. As has been argued elsewhere, the definitional scope of 'commercial' may well extend to services that are supplied on a not-for-profit basis.[9]

What about the concept of 'competition'? For example, does mere coexistence necessarily entail an element of competition? Or, in other words, are government-owned and -operated facilities (clinics, universities, etc.) automatically deprived of cover once commercial entities start targeting the same 'clientele'? Possibly not. In a study for the Canadian government, VanDuzer refers to the concept of one-way competition, based on the ruling of a WTO Dispute Panel (*Mexico - Telecommunications*).[10] In the current context, this could imply that private hospitals or universities, keen to poach customers with advertisements etc., may well compete with public-sector facilities which, as long as they remain indifferent, would nevertheless retain their 'governmental' status.

Such a one-way concept of competition appears particularly appropriate in a context where coexistence cannot be precluded. Consider the case of a country without any private domestic hospitals, where hospital services are provided for free by government-owned and -operated entities. Nonetheless, some patients may seek treatment abroad with a view, for example, to eluding lengthy waiting lists. The services supplied to them would fall under mode 2 (consumption abroad) of the GATS. Given the multi-modal structure of the Agreement, a wide definition that equates coexistence with competition, might thus severely undermine the scope of the carve-out.[11] This could not have been the drafters' intention. In this context, it is also interesting to note that, unlike other GATS provisions, such as Articles II and XVII (MFN and national treatment), Article I:3 simply refers to the existence of competition without requiring that 'like' services, 'like' service suppliers or the same modes be involved.

In quite a number of cases, a government entity may purchase services from private suppliers in order to make them widely available, on an exclusive basis and without charges, to the public in general. In this event, while the supply of the services may well fall under the carve-out of Article I:3, their initial purchase is likely to constitute government procurement, for which Article XIII:1 provides an exemption from MFN, market access and national treatment disciplines.[12]

(ii) Application to Financial Services

The governmental-service concept of Article I:3 applies across all sectors covered by the Agreement subject, however, to certain modifications for financial services. Para 1(b) of the Annex on Financial Services explicitly lists activities that are deemed to constitute governmental services, including 'activities forming part of a statutory system of social security' as well as 'other activities

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[9] It is interesting to note in this context that Article XXVIII(d)(i) of the GATS defines mode 3 (*commercial* presence) to include 'the constitution, acquisition or maintenance of a juridical person'. In turn, pursuant to Article XXVIII(l), 'juridical person' is intended to mean 'any legal entity duly constituted or otherwise organized under applicable law, *whether for profit or otherwise*' (emphasis added). Therefore, had the scope of commercial presence, as introduced in Article I:2(c) of the GATS been envisaged to cover profit-seeking activities only, the drafters might well have said so, without resorting to the wider definitional notion implied by Article XXVIII.

[10] In turn, the Panel had sought guidance from an English dictionary ('rivalry in the market, striving for custom between those who have the same commodities to dispose of'). See VanDuzer (2004) at 388 and 395.

[11] For further discussion of the concepts of 'likeness' in services, see Cossy (2008).

[12] See also Adlung (2006) at 474.

conducted by a public entity for the account or with the guarantee or using the financial resources of the Government'.[13] Pursuant to para 1(c) of the Annex, should a Member permit such activities to be conducted in competition, they are deemed to fall within the scope of the Agreement.

The twin criterion of GATS Article I:1 thus has been reduced to its second element, absence of competition. The (non-)commercial nature of an activity does not matter any more. In turn, this tends to widen the scope of the carve-out in those financial services that are referred to in the Annex, which may include health insurance.[14] However, as noted by VanDuzer (at 404), an additional issue must be considered in this context: The one-way concept of competition, as proposed before, no longer applies. Even if a public health insurer remains completely indifferent *vis-à-vis* private suppliers, its services would *not* qualify as 'governmental services' once the latter are allowed by the authorities to compete (para 1(c) of the Annex). Thus, while the absence of competition already suffices *per se* to trigger the carve-out in the areas concerned, it applies only as long as the relevant service segment remains closed for alternative suppliers, regardless of the parties' actual conduct.

Uncertainties remain. In particular, it might prove difficult to determine in some cases whether health insurance is actually part of a 'statutory system of social security'. Though there might be no problems in the case of Germany's *Allgemeine Ortskrankenkassen* and France's *Sécurité Sociale*, as far as basic (mandatory) coverage is concerned, the situation may be more complex in other countries.[15] It is true that ILO Convention 102 of 1952 lists medical care among the nine branches of social security, but can this provide guidance, for example, in the case of countries that have not ratified this Convention (e.g., the United States, Finland and the three Baltic States)? Also, the scope of a further definitional option circumscribing 'governmental services' in the Annex - 'other activities conducted by a *public entity* for the account or with the guarantee or using the financial resources of the Government' - may prove too limited in some cases. The definition of public entity explicitly excludes entities 'principally engaged in supplying financial services on commercial terms' (section 5(c) of the Annex).

The recent financial crisis has shown how quickly long-entrenched institutional and financial arrangements can or, rather, must be modified. These changes were normally in the direction of increased government involvement, at various levels. It might be possible, hypothetically at least, that government interventions that limit the scope for continued private/foreign participation are inconsistent with the specific commitments a Member had scheduled in the sector(s) concerned. Yet, again, the Annex on Financial Services provides more room for such initiatives than exists in other services. Members are permitted - 'notwithstanding any other provisions of the Agreement' - to take measures for prudential reasons, including measures 'to protect policy holders ... or to ensure the integrity and stability of the financial system' (Para 2(a)). These measures must not be used, however, 'as a means of avoiding ... commitments or obligations under the Agreement'.

(iii) Potential Policy Implications - Much Ado About (Almost) Nothing ...

The Agreement's carve-out for governmental services is essentially intended to ensure that governments remain free to select, organize and regulate entities involved in the provision of financial services as they fit, regardless of any obligations under the Agreement. The potentially most powerful among these obligations, which is horizontally applicable regardless of the existence of specific commitments, is the Most-favoured-Nation (MFN) principle, i.e., the requirement not to discriminate

[13] In turn, the term 'public entity' is further defined to include government-owned or -controlled entities that are 'principally engaged in carrying out governmental functions or activities for governmental purposes'; see para 5(c)(i).

[14] Of course, this has no implications for commercially *and* competitively organized health insurance systems such as those of the Netherlands or Switzerland.

[15] While it can be confidently assumed that, within their respective areas of competence, neither the *Ortskrankenkassen* nor the *Sécurité Sociale* are engaged in competition, it appears more doubtful, depending on the definitional benchmarks used, whether or not they operate on a commercial basis. The Annex' modification of the 'governmental service carve-out' might thus prove relevant.

between like foreign services and service suppliers. What is the relevance of the carve-out in this respect?

Think of situations where exclusive functions are conferred on an entity, e.g. a health insurer or a hospital operator, from a particular WTO Member which has been selected on an *ad hoc* basis, without the government giving regard to suppliers from other Members. Without the carve-out, it might prove difficult to defend such an initiative against claims of violation of the MFN obligation.[16] However, is this really important in practice? Are there any persuasive reasons that would call, in the general interest, for public-service functions to be conferred, in a discriminatory manner, on suppliers from one particular WTO Member at the expense of others? It is virtually impossible, at least for health services, to find compelling examples in the relevant literature.[17] By the same token, this also suggests that the modification of the carve-out for financial services, concerning in particular statutory systems of social security, may not seriously matter in practice.

In any event, the scope of the carve-out remains confined to the conditions governing the supply of the service in question. Follow-up effects in related sectors, which are organized on a commercial and/or competitive basis, would fall under the Agreement. For example, should the contributions to a health insurance scheme, which enjoys exclusivity status under government regulation, discriminate between employers of different foreign nationality, the MFN obligation would apply at least *vis-à-vis* those companies and/or their employees that supply services under the GATS. (In addition, national treatment would need to be ensured in the sectors for which the Member has scheduled relevant commitments.) According to Article I:3(a)(ii), the scope of the Agreement extends to measures taken by 'non-governmental bodies in the exercise of powers delegated by central, regional and local governments and authorities'.

There is one scenario, however, in which the uncertainties surrounding the carve-out may actually matter. Imagine a country undertakes commitments in a particular sector, say higher education, with a view, for example, to attracting international investors and promoting the associated transfers of skills and expertise. If the established public universities provide their services on a non-commercial and non-competitive basis, their existence can be safely ignored in this context. Otherwise, if they start competing for students, e.g., through advertisements, or introducing significant tuition fees, the situation appears less clear-cut. Once these universities cross the definitional Rubicon and can be deemed to compete and/or act on a commercial basis, any government measure in their favour would define the benchmark for the treatment of all universities, including private facilities that seek to provide like services.[18] The Agreement's market access and national treatment obligations would henceforth apply across all sector segments. However, this must not be a cause for concern. Again, the GATS is flexible enough to enable governments, for example, through tailor-made sector definitions, to avoid such effects (section III.B). If there is a challenge for governments, it lies in developing the experience and skills necessary for scheduling commitments in potentially sensitive sectors.

III. CURRENT PATTERNS OF HEALTH-RELATED COMMITMENTS

As noted before, the existence of access obligations under the GATS, and their precise scope, is determined essentially by the specific commitments a Member has inscribed in its service schedule. From an economic perspective, it is important to bear in mind that such commitments only confer trading rights. It remains open, of course, whether these are actually used. For example, potential hospital investors may remain on the sidelines because of factors not reflected in a country's schedule,

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[16] As a possible defence, Members also had the opportunity to list of an MFN exemption for the sector and measure concerned. However, as noted below, this option existed only at the time of Agreement's entry into force. See also Adlung and Carzaniga (2009).

[17] In a similar vein: Fidler (2004) at 36; Marchetti and Mavroidis (2004) at 533; and VanDuzer (2004) at 447.

[18] Adlung (2006) at 468.

including high initial cost of establishment, low insurance penetration, import restrictions on medical devices, etc.[19]

In non-committed sectors, the government remains free to operate whatever policy regimes or measures it deems appropriate, whether complete access prohibitions, unfettered liberalization or anything within this spectrum.[20] If there are constraints, these are associated mainly with preferential conditions that may benefit the services or suppliers of particular trading partners. Pursuant to the Agreement's MFN obligation, such preferences need to be extended in principle to all WTO Members unless they are covered by Preferential Trade Agreements (PTAs, section V.A) or a particular exemption from MFN treatment that could have been invoked at the time of the Agreement's entry into force in 1995 or, if later, the date of accession.[21]

A. Overview

In terms of commitments made, insurance services and hospital services mark the opposite ends of a spectrum: Apart from tourism, no sector has mustered more commitments than (life and none-life) insurance, currently scheduled by over 100 countries/economies, i.e. about two-thirds of WTO Members. Hospital and other health-related sectors are trailing, with no more than some 60 commitments, representing about one-third of the Membership (Table 2). The result for insurance services, in the wider context of financial services, may be attributed mainly to three factors: (i) The high political and economic stakes involved in the relevant negotiations which, out of dissatisfaction over the initial Uruguay Round schedules, were extended until end-1997; (ii) many governments' immediate interest in the universal availability, at competitive conditions, of core 'producer services' like finance, telecom or transport, which are key to overall economic performance;[22] and (iii) the fact that distributional or social policy concerns played no particular role in these negotiations, possibly reflecting the fact, *inter alia*, that the relevant portfolios are mostly in the hands of ministries, agencies and bodies concerned with financial sector regulation and supervision.

In contrast, health, education and other socially-relevant services did not attract any discernable degree of interest in the Uruguay Round. Those Members that finally scheduled commitments essentially did so on their own initiative, apparently without particular prodding from trading partners or potentially interested business circles. The role of the GATS, if any, has therefore remained confined to that of a 'supporting actor': not a liberalizing force, but an instrument to add credibility and predictability to existing regimes and, thus, lower the risk barrier of potential investors.

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[19] According to a case study for India (Rupa Chanda, 2007), quoted by Cattaneo (2009) at 8f. Footnote 9 to Article XVI:2(c) of the GATS clarifies that restrictions on the inputs used for the supply of services do not constitute 'limitations on the total number of service operations or on the total quantity of services output' that would otherwise need to be scheduled under that Article.

[20] Of course, even 'unfettered liberalization', in terms of market access and national treatment as defined under Articles XVI and XVII of the GATS, would not deprive a government of its ability to regulate in pursuit of basic public policy objectives. See Adlung (2006) at 479-483.

[21] In addition, the GATS contains several exception provisions which, if specified conditions are met, would allow government to disregard any provisions of the Agreement, including its MFN obligation. Typical cases not only include the 'prudential carve-out' for financial services, but also - regardless of the sector concerned - measures necessary to protect public life or health, public morals, etc. (Article XIV) or public security (Article XIV*bis*). Note, however, that resort to the former provisions (Article XIV) is conditional, *inter alia*, on the measures not being applied 'in a manner which would constitute a means of *arbitrary or unjustifiable discrimination between countries* where like conditions prevail' (emphasis added).

[22] It is certainly more than mere coincidence that the negotiations on maritime transport and basic telecommunications were extended as well beyond the timeframe of the Uruguay Round. While the former were finally suspended, in order to be taken up again in the current Round, the negotiations on basic telecommunications were successfully concluded in early 1997.

Table 2.
GATS Commitments on health-related services, October 2009 (Number of WTO Members) [a]

			Medical and dental services	Nurses, midwives, etc.	Hospital services	Health insurance [b]	Retail sales of pharma-ceuticals
Total number of commitments			66	35	58	107	43
Market Access	Mode 1	Full [c]	24 (-2)	9 (-1)	22	14	32 (-1)
		Partial	12	6	1	19	3
		Unbound	30	20	35	74	8
	Mode 2	Full [c]	49 (-3)	24 (-1)	50 (-1)	31 (-2)	39 (-3)
		Partial	14	10	5	16	1
		Unbound	3	1	3	60	3
	Mode 3	Full [c]	19 (-8)	7 (-3)	25 (-9)	23 (-16)	31 (-20)
		Partial	40	26	24	82	9
		Unbound	7	2	3	2	3
	Mode 4	Full [c]	0	0	0	2 (-1)	0
		Partial	60	33	54	95	40
		Unbound	6	2	4	10	3
National treatment	Mode 1	Full [c]	27 (-6)	10 (-3)	25 (-4)	41(-5)	33 (-10)
		Partial	10	6	1	24	2
		Unbound	29	19	32	42	8
	Mode 2	Full [c]	48 (-9)	24 (-4)	50 (-6)	54 (-10)	39 (-11)
		Partial	13	10	5	20	1
		Unbound	5	1	3	33	3
	Mode 3	Full [c]	32 (-13)	21 (-8)	37 (-18)	60 (-37)	38 (-32)
		Partial	28	12	17	39	3
		Unbound	6	2	4	8	2
	Mode 4	Full [c]	1 (-1)	2 (-1)	2 (-2)	10 (-1)	6 (-2)
		Partial	60	31	51	86	35
		Unbound	5	2	5	11	2

a EC Member States are counted individually.
b The numbers are approximate since it was not possible in the context of this exercise to verify in detail whether health insurance was covered in all cases under the classification systems adopted by individual Members for their financial services commitments.
c Figures in parenthesis: Reductions in the number of full commitments taking into account limitations inscribed in the horizontal section of the schedules. (These limitations apply across all scheduled sectors.)
Source: WTO Secretariat.

On average across all sectors, including those discussed in this paper, commitments under modes 2 (consumption abroad) tend to be the most open, whether for market access or national treatment.[23] No other mode has attracted as many full commitments, about one-half of all entries, that are not subject to any limitation. This apparently relaxed approach may be attributable in part to a perception that, since supplier and consumer interact in a foreign jurisdiction, they are largely beyond the scheduling Member's regulatory control.[24] In contrast, mode 1 (cross-border trade) has been left unbound in a significant number of instances. Two considerations may have played a role. In a variety of sectors, there might be a perception that, since supplier and consumer must be simultaneously present in order to perform a transaction (e.g., in the case of restaurant or hotel services), commitments on cross-border trade would be economically meaningless.[25] In other cases, governments may have hesitated to commit on the treatment of services that are produced in another jurisdiction, i.e., beyond national regulatory control, in order then to be send cross-border. Such

[23] For a more detailed overview of patterns of commitments, see Adlung and Roy (2005).
[24] See, however, above n 5.
[25] Nevertheless, this tends to ignore that, according to Article XXVIII(b) of the GATS, the supply of a service 'includes the production, distribution, marketing, sale and delivery'. It might be impossible to find a service where it is not feasible to provide at least one of these activities across borders. Further, the distinction between modes 1 and 2 may become blurred in cases involving electronic transactions. For example, if practitioners carrying out a surgery in country A are advised via Internet by an expert panel in country B, it might be argued that the service is actually provided within B to clients from A, given that the surgeons had initiated this transaction equivalent to a situation where they move abroad in person to seek advice.

hesitations may prove particularly relevant in regulation-intensive sector, including medical, hospital or financial services.[26]

Similar considerations may explain why, contrasting from mode 1, virtually all entries under mode 3 (commercial presence) imply an element of access liberalization. In many cases, however, strict limitations apply. Concerning market access, these may include restrictions on the number of suppliers, their turnover or assets, joint-venture requirements or foreign equity ceilings, while national treatment limitations frequently refer to *discriminatory* subsidy or regulatory regimes, training requirements, land ownership restrictions, and the like. Nevertheless, mode 3 is the most commercially important type of transaction, estimated to represent more than one-half of all services trade falling under the GATS, with modes 1 and 2 accounting, respectively, for some 25-30 and 10-15 per cent.[27]

Mode 4 has remained economically insignificant by comparison. Its small share in services trade, less than 5 per cent, may be attributed not only to geographic, cultural and similar barriers, but also to severe restrictions on market access. Commitments are often confined to the temporary presence of professional experts and specialists who move within multinational companies. Moreover, it needs to be borne in mind that the definitional scope of mode 4 under Article I:2(d) of the GATS is essentially limited to self-employed foreign service professionals and to foreign employees of foreign-owned or -controlled companies who provide services in a host country. Foreigners employed by domestically-owned facilities, whether hotels, hospitals or medical practices, are not covered.[28]

Of course, the existence of commitments must not be equated with actual conditions of access. In scheduling commitments, governments may have deliberately maintained a margin for future (restrictive) action. This margin is likely to have widened since the conclusion of the Uruguay Round in 1993/94, given that many services regimes have been modified in a liberal direction. Apart from the extended negotiations on basic telecommunications, concluded in early 1997, there is possibly only one occasion where significant degrees of liberalization have been committed under the GATS: WTO accessions. Virtually all accession schedules submitted since about 2000 contain phase-in commitments, most notably in financial services, that most likely reach beyond hitherto applied regimes.[29] The implementation periods may vary significantly between countries and sectors.

Nevertheless, there are also indications that commitments are not fully complied with in all cases. For example, a study examining the services policies in so-called transition economies, which account for many recent WTO accessions, found an inverse relationship between the level of individual countries' GATS commitments and the openness of their applied regimes. According to the authors, one possible explanation is a lack of commercial interest, on the part of other Members, in the markets covered and, thus, of incentives to enforce compliance through WTO dispute settlement. Many markets are simply too small in size.[30] Also, as noted before, existing commitments may not be tested in practice due to a lack of economic interest in a particular market.

B. Pursuit of Public-Policy Objectives via GATS Commitments: A Closer Look at Two Schedules (US and EC)

The scope of any GATS commitment can be modified in several ways. In order to accommodate sector-specific policy considerations or institutional constraints, a Member may either depart from the widely used sector classification, developed during the Uruguay Round (document MTN.GNS/W/120) and/or inscribe limitations under market access or national treatment for any of

[26] For example, Yeo (2002) considers the US-internal segmentation of competences concerning licensure and regulation of telemedicine as a major impediment to negotiating GATS commitments on mode 1.

[27] Magdeleine and Maurer (2008) at 18.

[28] WTO document S/C/W/301 of 15 September 2009.

[29] See Adlung (2007) and Marchetti (2008).

[30] Eschenbach and Hoekman (2006) at 417.

the four modes. Table 3 shows how these options have been used to circumscribe the scope and depth of the United States' commitments on hospital services.

Table 3.
Scheduling of limitations for hospital services: United States [a]

Modes of supply: 1) Cross-border supply 2) Consumption abroad 3) Commercial presence 4) Presence of natural persons

Sector or subsector	Limitations on market access	Limitations on national treatment	Additional commitments
8. HEALTH RELATED & SOCIAL SERVICES A. HOSPITAL AND OTHER HEALTH CARE FACILITIES - *Direct ownership and management and operation by contract of such facilities on a "for fee" basis*	1) Unbound* 2) None 3) Establishment of hospitals or other health care facilities … may be subject to *needs-based quantitative limits.* [...] 4) Unbound, except as indicated in the horizontal section	1) Unbound 2) Federal or state government *reimbursement of medical expenses is limited* to licensed, certified facilities in the United States or in a specific US state 3) None 4) None	

a Emphasis (italics) added to the original.
Note: This sectoral entry must be read in conjunction with limitations inscribed in the horizontal section of the schedule, including under national treatment: 'unbound' for subsidies under mode 2, and 'unbound' for the 'temporary entry and stay of natural persons' under mode 4 (without further qualifications).
Source: Document GATS/SC/90 of 15 April 1994.

First, government-owned and -operated facilities have been excluded, possibly with a view to preventing policies in these segments from being used as benchmarks for the treatment of commercial operators.[31] Second, the schedule reserves the authorities' right to prohibit new establishments under mode 3 (commercial presence) should there be, in their view, no need. Such 'needs tests' may be intended, for example, to prevent excessive capacity increases and any associated consequences for the length, intensity and, by implication, costs of hospital care. Finally, as indicated under national treatment / mode 2, federal and state governments in the United States are not willing to reimburse healthcare expenses incurred abroad. In turn, these restrictions may be deemed to avoid 'health tourism' and, by implication, help protect the integrity of domestic insurance plans. (Of course, there are more cynical explanations as well.)[32]

Since the United States has not scheduled any commitments on medical, dental and midwives services, it has retained full policy discretion in these sectors concerning the extension of market access and national treatment under any of the four modes.

Departing from the United States' approach, the schedule submitted by European Communities (EC 12) at the end of the Uruguay Round does not modify the sector coverage of hospital services nor contain national-treatment limitations with regard to treatment abroad (mode 2). This is interesting against the backdrop of EC-internal rulings concerning the portability of insurance cover under public health plans. In several cases since the late 1990s, the European Court of Justice

[31] Of course, such considerations prove relevant only insofar as the public suppliers do *not* meet the criteria for governmental services. Otherwise, they are excluded in any event from the scope of the Agreement.

[32] The question certainly arises who is protected from whom: The patients from treatment in sub-standard foreign facilities, less mobile population segments (and patients) from a gradual deterioration of domestically available supplies - or, rather, national healthcare providers from inconvenient competitors? According to Mattoo and Rathindran (2005), if only 10 per cent of the US patients that need treatment for 15 tradable low-risk ailments went abroad, the annual savings would amount to US$1.4 billion. International cost comparisons for surgical procedures are contained in Hermann (2009).

has confirmed the principle of patient mobility between the Member States for both ambulatory treatment and, subject to caveats, hospital care.[33]

The EC schedule does contain, however, two types of market-access limitations under mode 3. In a horizontal section, the Communities reserves the right, for all scheduled sectors, to subject 'services considered as public utilities … to public monopolies or to exclusive rights granted to private operators'.[34] Further, the sector-specific commitment for hospital services contains a variety of limitations, mostly referring to needs tests, governing the approval of capacity increases in individual Member States (France, Italy, Luxembourg and Netherlands).[35] Similar limitations have been inscribed for medical, dental and midwives services by some EC Members.[36]

Interestingly, the Communities' commitments on educational services, which may be subject to similar policy concerns, have been modified, US-style, in sector coverage. The commitments are explicitly limited to '*privately funded* services'. At first glance, this modification may appear somewhat redundant since the horizontal section already excludes public utilities from coverage. However, while the latter exclusion only concerns market access under mode 3, though on a horizontal basis, the change in sector scope extends to all modes of supply and to national treatment as well.[37]

The commitments on financial services the US and EC scheduled at the end of the extended negotiations in 1997 do not provide for any market access in non-life insurance, including health insurance, under either modes 1 or 2 (cross-border trade and consumption abroad, respectively). As regards mode 3 (commercial presence), the *United States* inscribed a variety of potentially relevant limitations, mostly specific to individual US States, which may hamper, but not preclude, foreign entry (for example, there are citizenship requirements concerning members of the board of directors, and in several US States, branches of foreign insurers can be licensed only if they had been licensed before in another State). Similarly, the *European Communities* has scheduled a range of mode 3-related limitations in this sector, specific to individual Member States; these limitations should be read in conjunction with the Communities' horizontal exclusion concerning public utilities.

C. Interpretation Problems (?)

(i) The Scope of National Treatment

The juxtaposition of the EC and US schedules reveals some interesting interpretational differences. These concern in particular the application of the national-treatment obligation to services supplied from, or consumed in, another Member's territory, i.e., the scope of modes 1 and 2. A case in point is the treatment of subsidies. While the EC has not inscribed any cross-sectoral national treatment limitations for subsidies under modes 1 and 2, the United States and some other WTO Members, including Norway, Liechtenstein and Switzerland, have elected to do so. The EC also omitted from its consolidated EC-25 schedule the subsidy-related limitations that some of its recently

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[33] See, for example, Hatzopoulos (2002) and Davies (2007).

[34] A related footnote explains that '[p]ublic utilities exist in sectors such as … health services, transport services and services auxiliary to all modes of transport. Exclusive rights on such services are often granted to private operators, for instance operators with concessions from public authorities, subject to specific service obligations. Given that public utilities often also exist at the sub-central level, detailed and exhaustive sector-specific scheduling is not practical'. In a similar vein, under mode 3 (national treatment), the Communities' schedule contains a subsidy-related limitation stipulating that '[t]he supply of a service, or its subsidization, within the public sector is not in breach of this commitment' (Document GATS/SC/32 of 15 April 1994).

[35] For example, the entry for the Netherlands reads: 'Quantitative economic needs test fixed by a health plan allowing for a maximum number of beds related to the population of each health region'.

[36] Germany is covered by the following limitation: 'Access restricted to natural persons only. Economic needs tests for medical doctors and dentists who are authorized to treat members of public insurance schemes. The criterion is shortage of doctors and dentists in the given region'.

[37] See also above n 31.

acceded Members, including Estonia, had initially inscribed under modes 1 and 2 in their national GATS schedules. The Communities has noted that there is no need to list limitations should subsidies not be extended to service suppliers located outside the territory of the Member concerned.[38] Reference has been made in this context to the national treatment provisions of Article XVII of the GATS and the 'Scheduling Guidelines', a background document endorsed by WTO Members, which is expected to govern the scheduling of commitments.[39]

Both Article XVII and the Scheduling Guidelines refer to, and distinguish between, the treatment of services and that of service suppliers. Yet, while the Guidelines (paras 15 and 16) explicitly provide that bindings under Article XVII do not require Members to offer domestically extended subsidies to *suppliers* established in another jurisdiction, there is no similar clarification concerning the status of foreign *services* that a Member's nationals may have imported from or consumed abroad.[40] Contrary to the treatment of suppliers, in this case, the Member can be assumed to have meaningful jurisdiction over, and the means to discourage its nationals from, the consumption of foreign-produced services. Potentially relevant measures may be available under national tax, subsidy or reimbursement schemes. (For example, a Member may decide (or not) to allow its nationals to deduct, in their tax declarations, the costs of *services* provided by suppliers established abroad; such services may include distance learning courses, mortgage credits, ship repairs, medical treatments, laboratory analyses, or any types of insurance.)[41] It might have been such considerations that prompted the United States (Table 3) as well as Poland, Latvia and Slovenia prior to their EC accession, to inscribe national treatment limitations for hospital services concerning the non-reimbursement of expenses incurred abroad.

There are indications that the EC's approach is not cast in stone. A closer look at the recently concluded Economic Partnership Agreement with the CARIFORUM States reveals two interesting modifications compared to the Communities' GATS commitments. First, the EC has narrowed down the coverage of health and social services, including hospital services, to 'privately-funded services' (section V.A); and, second, the commitments under modes 1 and 2 explicitly exclude subsidies from coverage. While the first modification is contained only in the Communities' EPA schedule, the latter limitation applies horizontally across all sectors and modes committed by the signatory States under this Agreement (Article 60(3)).[42]

Even a more extensive interpretation of the commitments scheduled under modes 1 and 2, which recognizes the significance of national treatment disciplines for *services* traded under these modes, remains subject to an important caveat: the requirement of likeness. Thus, a laboratory service or an X-ray analysis provided in another territory would qualify for national treatment under modes 1 or 2 only if they are like the services produced, and admitted for sale, by a domestically-owned lab within the territory of the Member undertaking the commitment.[43]

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[38] WTO document S/C/W/273 of 9 October 2006, at 298.

[39] The current version of the Guidelines is contained in WTO document S/L/94 of 28 March 2001. For information on their history and legal status see Leroux (2007) at 760-762.

[40] Para 15 of the Guidelines confirms that '[t]here is no obligation in the GATS which requires a Member to take measures outside its territorial jurisdiction. It therefore follows that the national treatment obligation in Article XVII does not require a Member to extend such treatment to a service supplier located in the territory of another Member'. According to para 16, 'Article XVII applies to subsidies in the same way as it applies to all other measures.' Para 30 further clarifies that '[w]hatever the mode of supply, obligations and commitments under the Agreement relate directly to the treatment of services and service *suppliers*. They only relate to service *consumers* insofar as services or service suppliers of other Members are affected. It should be noted that a Member may only be able to impose restrictive measures affecting its *own* consumers, not those of other Members, on activities taking place outside its jurisdiction' (emphasis in the original).

[41] The Scheduling Guidelines provide that mode 2 also covers situations in which only the property of the consumer moves abroad or is situated abroad, referring to ship repair as an example (para 29).

[42] See also Sauvé and Ward (2009) at 35.

[43] For further discussion of the notion of likeness in services trade, see Cossy (2008).

(ii) Definitional Issues: Subsidies

As mentioned before, many Members have scheduled subsidy-related national treatment limitations under one or more modes of supply. These limitations are typically scheduled on a horizontal basis, thus applying to all sectors on which commitments have been undertaken. However, what are 'subsidies'? As long as a Member grants full national treatment, this issue does not really arise: The authorities are committed not to operate any measure, regardless of how it might be defined, that modifies 'the conditions of competition' in favour of its own like services or service suppliers (Article XVII:3). But what is the scope of a subsidy-related national treatment *limitation*? Beyond direct financial benefits and tax privileges, would it also cover, for example, the provision of necessary 'inputs', such as fuel, electricity, professional liability insurance, etc., at more favourable than the generally available conditions? If the definition applicable to subsidies in merchandise trade, under the Agreement on Subsidies and Countervailing Measure, is of any guidance, the answer would most likely be in the affirmative. However, this definition has not been confirmed for services.

Though the GATS (Article XV:1) contains a negotiating mandate for subsidies, with a view to developing disciplines that might be necessary to avoid trade distorting effects, Members have not yet agreed on a common working definition on what might be covered - in close to 15 years.[44] Concerns about potential repercussions on their own policies might have made them hesitate. For similar reasons, there may be little appetite, should own suppliers be confronted with dubious practices abroad, to invoke and seek legal clarification under the Agreement's dispute settlement provisions. Current uncertainties are thus likely to persist for quite some time.

The absence of a common definition might not only pose problems for the interpretation of GATS schedules, but also for obligations under other trade and investment agreements that use similar terms (section V).[45] Nonetheless, the services chapters of some preferential trade agreements do contain additional elements. For example, the agreements concluded by the United States, in their chapters on cross-border trade (largely equivalent to modes 1 and 2 of the GATS), expressly exclude from coverage 'subsidies and grants provided by a Party, including *government supported loans, guarantees and insurance*' (emphasis added). However, this still remains a rather sketchy definition if compared, for example, with that provided in the Agreement on Subsidies and Countervailing Measures.[46]

D. <u>When Commitments Might Need to be Changed (or Not)</u>

Health services are among those sectors for which it is particularly difficult to anticipate the duration of countries' existing legal and institutional frameworks. Modifications abound - for budgetary, quality and/or social policy reasons. In many cases, it might be possible to accommodate such modifications within current GATS commitments. However, there are also instances, hypothetically at least, where commitments would need to be adjusted in order to bring them in tune with new sector regimes.

In a number of countries, capacity increases in the health sector (number of physicians, dentists, etc.) are linked, *inter alia*, to the financial status of the public insurance scheme or to shortages/oversupplies in particular segments or regions. In other words, the number of new licences that are issued by the competent authorities might vary significantly from year to year and, possibly, across regions. However, such variations - or more precisely: the underlying need for flexibility - can easily be accommodated in a GATS schedule. A case in point is the needs test concerning the establishment of new hospitals inscribed by the United States under market access, mode 3 (Table 3).

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[44] Of course, these negotiations are about additional disciplines, beyond the scope of the MFN and, in scheduled sectors, national treatment obligations that will continue to apply in any event.

[45] The same applies to concepts such as 'governmental services'.

[46] For example, the Agreement's scope explicitly extends, *inter alia*, to a government's provision of goods and services other than general infrastructure, government purchases of goods, and the provision of income or price support (Article I:1).

Similar tests have been scheduled by seven EC Members (Belgium, France, Italy, Luxembourg, Netherlands, Spain, and Portugal).[47] In the same vein, Germany and the UK have inscribed needs tests under medical, dental and midwives services;[48] while Denmark and France have reserved the right to regulate the number of doctors, dentists and midwives on a 12- or 18-months basis.[49]

Apart from such modifications of established regimes, of course, there are also discussions in various countries about the need for institutional changes in pursuit of the - financial, social, etc. - policy objectives referred to above. Such changes could consist, for example, of the extension of current insurance monopolies to additional, hitherto excluded population segments in order to improve their situation or, conversely, to tap high-income earners as an additional source of revenue. For example, the issue has been raised in Germany whether the public sickness fund should be converted into a universal '*Bürgerversicherung*', which would provide basic coverage across all population segments, including those 10 per cent that are not currently required to contribute.

The extension of a governmental service (section II.B) to additional activities and the ensuing legal obligations, are not explicitly addressed in the GATS. A closely related scenario, however, is clearly captured by Article VIII:4: A government that envisages granting monopoly rights in areas subject to specific commitments is required to notify its intention to the Council for Trade in Services and, at the request of potentially affected Members, negotiate compensatory adjustments, in the form of new and/or more liberal commitments, elsewhere in its schedule. It is only after a solution has been found, involving arbitration if need be, that the monopoly may be introduced. Against this background, it may appear unreasonable to assume that Members would be free to extend, at their discretion, a governmental-service segment within a larger sector on which commitments have been undertaken. This might defy the very purpose of such bindings - i.e., providing a transparent and predictable framework for international trade and investment. As noted by VanDuzer in a similar context, a treaty interpreter must be expected 'to divine what the parties intended at the time the treaty was concluded'.[50]

Nevertheless, not everybody may be ready to concur. Sceptics might wonder whether the existence of explicit rules for one scenario - creation of monopolies in committed areas - and the non-treatment of a parallel scenario - introduction of a governmental service - is intended to convey a message: no requirement to compensate in the latter case.

The GATS also imposes certain constraints on the conduct of public monopolies, e.g., in basic health insurance, which seek to diversify into other areas, such as supplemental insurance, where they are in competition with private suppliers. Article VIII:2 is unequivocal in this regard: 'Where a Member's monopoly supplier competes, either directly or through an affiliated company, in the supply of a service outside the scope of its monopoly rights and which is subject to that Member's specific commitments, the Member shall ensure that such a supplier *does not abuse its monopoly position* to act in its territory *in a manner inconsistent with such commitments*' (emphasis added).[51] Again, should a government pursue such intentions, the relevant commitments would need to be withdrawn or modified accordingly.

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[47] Of course, given the Communities' horizontal exclusion of public utilities, the admission or extension of public hospitals may be exempt from such tests. See section III.B.

[48] Germany: 'Economic needs test for medical doctors and dentists who are authorized to treat members of public insurance schemes. The criterion is shortage of doctors and dentists in the given region'. United Kingdom: 'Establishment for doctors under the National Health Service is subject to medical manpower planning'.

[49] In addition, Germany, Greece, France and Portugal reserved the right to impose nationality requirements.

[50] VanDuzer (2004) at 464f.

[51] Note that these provisions relate only to situations where a supplier is 'authorized or established formally or in effect' by a Member as the sole supplier of a service (Article XXVIII(g)), and do not cover exclusive positions which have been gained without government interference.

Nevertheless, there have been only very few initiatives to date where governments have sought to modify existing commitments under the GATS - and none in the sectors dealt with in the current context.[52] The dearth of relevant moves might be attributed to several factors:

(i) The low number of existing commitments, especially in potentially sensitive sectors such as health and education, and, thus, the limited potential for conflict;

(ii) ongoing liberalization moves during the past 1½ decades, which have further eroded the substance of 'old' bindings;

(iii) governments' expectation that trading partners tolerate (mild) infringements especially in politically and socially delicate cases;[53]

(iv) country-internal information and coordination problems between government and private sector (e.g., companies affected by 'GATS-minus' treatment might be unaware of their rights); and, not least,

(v) the absence of any incentive to pro-actively renegotiate WTO commitments prior to the introduction of potentially inconsistent policies.

The worst conceivable outcome of a dispute is a ruling to bring the measure(s) concerned into conformity with the Member's GATS obligations and, possibly, in the case of continued non-compliance, an arbitrator's decision on compensatory commitments in other areas that are of interest to affected trading partner(s). The whole process might take one or two years. As distinct from investment treaties (section V.B), there is virtually no basis in the WTO for aggrieved Members to claim compensation for the losses experienced by their suppliers due to the breach of WTO obligations.[54]

IV. DEVELOPMENTS IN THE DOHA ROUND

Given the diversity of - perfectly legitimate - trade protective instruments in services, combined with a gamut of regulatory requirements, it is extremely difficult to develop meaningful indicators that would reflect actual or scheduled access conditions. The most ambitious and promising attempt in this respect has been made recently by Gootiiz and Mattoo, based on surveys in 24 OECD countries and 32 developing and transition economies.[55] For key categories of measures, existing trade barriers were rated, according to their levels of restrictiveness, on a five-point scale in order then to be compared with what the countries had scheduled under the GATS and their best offers submitted in the Doha Round to date. The main focus of the study was on the most economically relevant services, in terms of expected cross-sectoral effects on trade and competitiveness: financial services (including life insurance), telecommunications, retail distribution, maritime transport, and selected professional services (accounting, auditing, and legal services). The findings: While the offers tend to improve the security of access, in so far as their implementation would bring the scheduled commitments somewhat closer to the applied regimes, they do not involve any element of liberalization. On average, the best offers are still 1.9 times more restrictive than what currently exists in practice …

A more detailed study of Doha-Round developments in financial services confirms this sobering picture. At the time of the study, September 2007, 65 Members, counting the EC Member

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[52] The only re-negotiations completed so far under Article XXI concern changes in the EC schedule to accommodate the enlargement to EC 25.

[53] As noted before (section III.A), the level of tolerance might be particularly high in the case of small countries/markets.

[54] The only exceptions concern anti-dumping and countervailing duties where GATT panel reports, in a handful of cases, recommended that these be reimbursed. See Goh and Ziegler (2003) at 353.

[55] Gootiiz and Mattoo (2009) at 1013-1015.

States individually, had submitted offers in this sector. Overall, their substance was judged to be 'very poor'.[56] Only six Members added new subsectors, and in most cases no new business or access opportunities would be granted. In particular, many developing countries were found to be 'very far from offering to bind the current levels of openness'; and Argentina, China, Colombia, Malaysia, the Philippines and Thailand had not submitted any offers in financial services. Nonetheless, this bleak assessment needs to be set against the comparatively meaningful commitments, in commercial terms, that resulted from the extended negotiations concluded in 1997. Financial services are commonly considered to be one of the few 'success stories' of the GATS. Moreover, as in other sectors, there is still the possibility of improvements during the final stretches of the Doha Round.

Concerning healthcare services (medical, dental and midwives services as well as hospital services), the Round was even more of a non-event to date. The negotiating momentum was weaker than in any other large sector; it did not even suffice for the formation of a group of like-minded Members to pursue common interests. (In total, some 20 such 'plurilateral groups', including on educational services, constituted themselves in the wake of the Hong Kong Ministerial Meeting of December 2005.) Indeed, several participants, among them the Canadian government and the EC Commission, expressly confirmed their unwillingness in these sectors to undertake any commitments (Canada) or to improve on what they have in their current schedules.[57] Overall, of the 95 Members that are covered by services offers (end-2009), only 11 envisage new or improved commitments in healthcare-related areas. These are all developing countries.

If the services offers submitted to date were of any guidance, the already existing gap between GATS commitments on intermediate (producer) services, including finance, telecom and a broad range of business services, and those on consumer-oriented sectors, such as health, education and audiovisual services, is set to widen considerably.[58]

V. COMMITMENTS IN OTHER POLICY CONTEXTS

There is a strange contrast in the public perception of international treaty obligations. While trade-sceptical NGOs tend to focus on what is going on (or not) in the WTO, as the most obvious and convenient target, relatively little attention, if any, is being paid to a very rapidly rising number of preferential trade agreements (PTAs), recently extending to services as well, and to an even more dramatic proliferation of bilateral investment treaties (BITs). Such treaties normally cover and protect all commercial investments carried out by investors of one party in the territory of the other party, including in health-related services. If the number of disputes were to be used as an indicator of an agreement's impact on international trade and investment, the GATS would trail not only its counterpart in merchandise trade, the General Agreement on Tariffs and Trade (GATT), but also the 2'000-odd BITs that are currently in force around in the world. While no more than a handful of services-related disputes were brought under the GATS in the 15 years since the WTO's entry into force in January 1995, over 120 such cases were raised under investment treaties over the same period.[59]

[56] Marchetti (2008) at 327.

[57] For example, in June 2002, the then EC Trade Commissioner Pascal Lamy wrote to Emilio Gabaglio, General Secretary of the European Trade Union Confederation (ETUC) that, as far as health and education were concerned, 'the Commission takes the view that the EC should not make any requests to developing countries in these sensitive sectors and it has no intention of making any offers in these sectors'.

See http://trade.ec.europa.eu/doclib/docs/2004/april/tradoc_116645.pdf

[58] For a discussion of the underlying political, institutional and economic factors, see Adlung (2009).

[59] Of the WTO disputes, only three dealt exclusively with alleged infringements of GATS commitments (*Mexico - Telecoms, US - Gambling,* and *China - Publications and Audiovisual Products*). By the end of 2008, UNCTAD (IIA Monitor No.1, 2009) counted 317 known arbitration cases lodged under relevant investment treaty provisions, including claims under NAFTA and the Energy Charter Treaty. Of these, less than a handful date from before 1995. Using the shares provided in preceding UNCTAD publications (2007 and 2008), it may be assumed that about two-fifths of all claims concern services. Over 90 per cent were filed by developed-country investors.

A. Preferential Trade Agreements (PTAs)

As indicated before, medical and hospital services have played a very modest role under the GATS to date. This applies not only in terms of current commitments, where they range almost at the bottom of the 'sector league', but also with regard to the offers submitted in the Doha Round. The absence of negotiating momentum (and interest) in these services might also be reflected in preferential trade agreements covering services. More than 60 such agreements have been concluded and notified to the WTO so far. Comparable to GATS commitments, the general focus is on producer- rather than consumer-oriented services.[60]

There are cases, where healthcare-related commitments under preferential trade agreements are even more narrowly defined than the GATS schedules of some of the signatories. For example, as indicated before, the European Communities' current GATS schedule, mostly dating back to 1993/94, includes commitments on hospital services as captured by the relevant classification number (CPC 9311) contained in the Sectoral Classification List (MTN.GNS/W/120). For the then 12 Member States, these commitments are without limitations on national treatment under modes 2 (consumption abroad) and 3 (commercial presence).[61] In contrast, the commitments undertaken by the Communities in the context of CARIFORUM Economic Partnership Agreement (EPA) reduce the scope of health and social services to 'privately funded services'. They thus exclude the public sector segment which - via portability of health insurance entitlements - might prove commercially lucrative for a number of CARIFORUM countries. Of course, regional agreements do not deprive the signatories of their rights under the GATS. The CARIFORUM Members remain free to insist on their partner's compliance with its GATS commitments, and *vice versa*. Whether they are prepared politically to launch a challenge is another question, however. In any event, the EPA shows how cautious many governments are in dealing with health services in trade agreements.

To a certain extent, the North American Free Trade Agreement (NAFTA) might be viewed from a different perspective. NAFTA follows a top-down approach, i.e., it starts from the assumption that all sectors are covered unless specifically excluded. Such agreements not only tend to be deeper in terms of liberalization effects, but also wider in sector reach than the parties' GATS commitments. Thus, NAFTA's national treatment obligation extends across virtually all service sectors, barring specified reservations.[62] The NAFTA chapters governing investment and cross-border trade in services (equivalent to modes 1 and 2 of the GATS, plus elements of mode 4) allowed the parties to list non-conforming measures in schedules annexed to the Agreement with a view to exempting them from several core disciplines, including MFN and national treatment. This possibility existed not only with regard to the continuation of existing measures, but also the adoption of new ones. It was used by the three signatories to list reservations for measures adopted or maintained with respect to 'social services that are established or maintained for a public purpose'. In this context, income security or insurance, social welfare and health are explicitly referred to, *inter alia*. Nevertheless, some observers have pointed out uncertainties concerning the interpretation of 'public purpose'. For example, to what extent can its continued existence be assumed if the intensity of government funding or regulation decreases?[63]

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[60] Interestingly, the sector-related parts of a recent publication analysing PTAs in services deal with financial, telecommunications, distribution, postal some other services, but pay no attention to the medical and hospital sectors. See Marchetti and Roy (2008). For a listing of preferential agreements in the Asia-Pacific region containing provisions on health and social services or health-related products, see Mikic (2007) at 20-22.

[61] As discussed before, it appears reasonable to assume that full commitments on mode 2 are tantamount to guaranteeing insurance portability under public health schemes to nationals consuming like services abroad. In contrast to hospital services, the EC's GATS commitments on education services are confined to 'privately funded education services' (WTO document GATS/SC/31 of 15 April 1994), thus excluding any government-sponsored scholarships from coverage.

[62] However, NAFTA is more lenient than the GATS concerning the compliance of sub-federal entities (states, provinces, municipalities) with core disciplines. See Adlung and Carzaniga (2008) at 364.

[63] Choudhury (2009) at 221-226.

The investment chapter of NAFTA, like those of other PTAs concluded by the United States, contains typical features of an investment treaty (see below), including the need for compensation in the case of direct or indirect nationalization or expropriation (Article 1110) and the availability of investor-to-State arbitration (Article 1115ff). At the time of writing, Canada's NAFTA obligations were in the process of being tested by a US-owned commercial provider of healthcare services. The case revolves around claims of discriminatory and unfair treatment, due, *inter alia*, to the alleged lack of transparent funding mechanisms.[64]

As concerns *insurance services*, it appears that only few PTAs provide for effective liberalization. They involve the United States which, according to Marchetti, 'has consistently obtained the highest standards from its co-signatories'. For example, Australia, Chile and Singapore were prepared to undertake more liberal commitments in their agreements with the US than in those with other countries.[65] The focus clearly has been on liberalizing commercial presence (mode 3).

B. Bilateral Investment Treaties (BITs)

(i) The Status of Investment Treaties under the GATS

Trade and investment issues have traditionally been viewed from different angles and treated separately. However, as far as trade in services is concerned, the GATS has blurred the borderline between the two areas. Article I:2(d) of the Agreement defines trade under mode 3 to consist of the supply of a service 'by a service supplier of one Member, through commercial presence in the territory of any other Member'. This implies that investment-related measures which impinge on - or 'affect' - such supplies are within the scope of GATS.[66] The implications are potentially significant, given that mode 3 represents some 55-60 per cent of all services trade under the GATS (section III.A).

Virtually all WTO Members have concluded and ratified investment treaties, with variations in scope and content.[67] At present, some 2'000 such treaties are in force. They are typically organized in the form of (overlapping) hub-and-spoke systems around major source countries, such as Germany, Switzerland, China and the United Kingdom, which tend to use their own templates. Each of these four countries accounts for over 100 treaties. Most of them are without limitations in sector coverage, thus extending across the whole economy, including all service sectors, of the signatory States.[68]

BITs typically contain a range of obligations - including 'fair and equitable treatment' and national treatment post-establishment, in some cases even pre-establishment - that do have counterparts in the GATS. These include the requirement, in scheduled sectors, to 'ensure that all measures of general application affecting trade in services are administered in a reasonable, objective and impartial manner' (Article VI:1) and the commitment to national treatment pursuant to Article XVII. Moreover, there are obligations in BITs that 'affect' trade in services, but are without direct equivalents in the GATS. Cases in point are labour- or procurement-related clauses and a compensation requirement for expropriations (see below and Annex Table).

The 40-odd treaties concluded by the United States are special cases insofar as their national-treatment guarantee covers the pre-establishment phase as well. This implies that domestic liberalization measures must be extended immediately to foreign investors, thus removing any scope

[64] For information see the Website of Canada's Ministry of Foreign Affairs and International Trade: www.international.gc.ca/trade-agreements-accords-commerciaux/disp-iff/centurion_archive.aspx?lang=en. Kulkarni (2009, at 280-282) provides an overview of selected investor-to-State disputes under NAFTA that seem to involve basic public services. The emphasis is on water and environmental services, however.

[65] Marchetti (2008) at 330.

[66] Article I:1: 'This Agreement applies to measures by Members affecting trade in services'. See also Ortino and Sheppard (2006) at 206-208.

[67] The only WTO Members not to have ratified any BIT are Brazil and Suriname (situation in mid-2006, according to Adlung and Molinuevo (2008) at 40-43).

[68] For a discussion of core features, see, for example, various contributions in Muchlinski et al (2008).

for policy experimentation at the national level.[69] The sector scope of the US-promoted treaties is subject, however, to certain reservations. On the US side, the services-related reservations are concentrated chiefly on the insurance, banking and certain transport and communication sectors. Hospital and medical services are not among them. In turn, most of the United States' treaty partners - composed of LDCs, developing countries and several transition economies that have since joined the EC - have also scheduled reservations, with differences in focus. In 15 cases, these include insurance services; health services have been exempted only once.[70] The precise sector scope of these reservations is difficult to ascertain, however. Unlike most GATS schedules, BITs do not contain references to an international classification system.

A typical example of GATS-plus obligations in investment treaties is a compensation requirement for takings of property. (If compensation is denied to both domestic and foreign investors, the Agreement's national-treatment obligation, whose scope is limited in any event to scheduled sectors, would be of no help.) As discussed elsewhere, an expropriation conducted in a non-discriminatory manner, according to the principle of due process and serving a public purpose (e.g., the termination of commercial activities in an environmentally sensitive region) might be considered GATS-compatible, even if the foreign investor has received no adequate compensation for the seizure of property.[71] It is important to note in this context that the property rights usually protected under BITs extend to the enjoyment of intangible assets, including the right to make profits and distribute dividends.[72] While GATS provisions such as Articles VI, XVI and XVII may play a role in protecting an investor against unlawful expropriations in certain circumstances, BIT disciplines are more specific and, hence, more immediately relevant. As indicated before, these disciplines cannot be enforced only via State-to-State arbitration; most treaties also allow for investor-to-State arbitration. The latter element, combined with various GATS-plus provisions, has led observers to conclude that the GATS 'is less restrictive' than standard BITs.[73]

In terms of modes of supply, the definitional scope of investment treaties rarely reaches beyond mode 3 of the GATS (commercial presence), with the possible exception of some mode 4-related elements (presence of natural persons). Such treaties are thus difficult to reconcile with the criteria for preferential trade agreements which, according to GATS Article V:1 (footnote 1), 'should not provide for the *a priori* exclusion of any mode of supply'. Consequently, in areas of BIT/GATS overlap, the MFN clause under the Agreement would apply. It provides for the 'multilateralization' of BIT obligations, whether these specify comparative standards of treatment (e.g., national treatment) or other disciplines on government conduct, that reach beyond the parties' obligations or commitments under the GATS.

As mentioned above, there are essentially two possibilities to prevent the (unwarranted) 'multilateralization' of investment disciplines: Their integration into preferential trade agreements pursuant to Article V of the GATS or, if covered by self-standing investment treaties, the listing of an MFN exemption for such treaties. Interestingly, the latter possibility was used by no more than one-tenth of the WTO's current 150-odd Members.[74] Nevertheless, despite its potentially significant role, the 'supporting actor' (GATS) has remained off the stage to date: BIT-related complaints have never been raised in the WTO.

The absence of such complaints might be attributed mainly to two factors: First, in quite a number of cases, the governments concerned may have extended their BIT obligations, in particular

[69] Recently, some more countries have included, to varying degrees, national treatment obligations on a pre-establishment basis in their BITs (e.g., Canada, Finland and Japan).

[70] Again, it is important to bear in mind that no such reservations are necessary for sectors that are closed and will remain closed for all private investors, whether foreign or national.

[71] Adlung and Molinuevo (2008).

[72] Reinisch (2008). Concerning the treatment of 'regulatory expropriation' under BITs, see Choudhury (2008) at 792-797.

[73] Kulharni (2009) at 252.

[74] See, for example, Adlung and Carzaniga (2009).

the national-treatment obligation concerning access to investment grants, production subsidies etc., automatically to investors from all countries. Thus, there is no scope for friction. Second, should monetary compensation be denied, e.g., in expropriation cases, investors from a non-BIT signatory have little to gain from a WTO dispute. Even if endorsed by a panel, relevant complaints might prove ineffective. As indicated before, WTO dispute rulings are essentially prospective in nature, e.g., calling on Members to bring their policies in conformity with relevant provisions, but do not provide for retrospective compensation.[75]

(ii) Disputes under BITs

Given the absence of a 'government filter', BIT-disciplines tend to have more bite, whenever directly applicable, than any multilateral or 'multilateralized' equivalents under the GATS. Individual investors are keen to defend what they consider their legitimate commercial interests without giving particular regard to overriding policy considerations. Moreover, as already indicated, arbitration cases under BITs also enable an aggrieved company to seek monetary compensation for the damages suffered.[76] Thus, not surprisingly, since the WTO's entry into force in 1995, which coincides with a sudden surge of newly concluded investment treaties, the caseload under such treaties dwarfs by far the few disputes launched under relevant GATS provisions.

Compensation requirements under BITs might prove relevant whenever a State redraws the borderline between private- and public-sector provision of a particular service in favour of the public sector. A recent study refers, for example, to legislation in the Czech Republic, in early 2006, which curtailed the ability of private commercial hospitals to be reimbursed under health insurance schemes. Although accessibility to hospitals has improved overall, observers warned that there could be arbitration claims under investment treaties should any of the private hospitals be owned by foreign investors.[77] More recently, under a BIT between the Netherlands and the Slovak Republic, a Dutch company reportedly filed an arbitration claim challenging its treatment under new legislation which reversed some market-oriented policy reforms. Under the disputed law, health insurers in the Slovak Republic are required, *inter alia*, to plough profits back into the healthcare system rather than paying dividends.[78] As indicated before, it might prove difficult in such cases to find a violation of GATS provisions.

It might well be argued that 'one major disadvantage' of GATS commitments is the difficulty of policy reversals in case the commitments undertaken are (too) closely geared to the prevailing regimes.[79] However, such statements are somewhat incomplete as long as the potentially tighter policy constraints associated with BITs are not taken into account as well. And these constraints have been accepted by a far higher number of WTO Members, intentionally or otherwise, than those having assumed health-related commitments under the GATS. Though there are public-interest or -welfare clauses in most BITs, their significance would need to be vetted case-by-case. Moreover, these clauses are unlikely to shield from other types of claims that might be brought under such treaties, including those relating to 'fair and equitable treatment'.[80]

In concluding this section, it is tempting to quote comments made at a conference on WTO law (2008): 'Contrary to the multilateral trading system, no multilateral institution permanently

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[75] Goh and Ziegler (2003). Article 19:1 of the Understanding on Rules and Procedures Governing the Settlement of Disputes reads: 'Where a panel or the Appellate Body concludes that a measure is inconsistent with a covered agreement, it shall recommend that the Member concerned bring the measure into conformity with that agreement. In addition to its recommendations, the panel or Appellate Body may suggest ways in which the Member concerned could implement the recommendation'.

[76] For more details see Verhoosel (2003).

[77] Choudhury (2008) at 802f.

[78] Investment Arbitration Reporter, 2(3), 10 February 2009 and 2(16), 14 October 2009. The multi-faceted relationship between bilateral investment treaties and EU law is discussed in Eilmansberger (2009).

[79] For example Blouin (2006) at 191.

[80] Choudhury (2008).

administers BITs or hosts a dispute settlement system to resolve disputes about the interpretation and application of those treaties. The proliferation of BITs has resulted in legal chaos, it was observed. Contrary to the WTO, investors can have standing before bilateral investment tribunals and enjoy individual rights under the treaties administered by those tribunals. Contrary to remedies available in the WTO, compensation of retrospective damages is available under BITs. Contrary to the WTO covered agreements, BITs are sometimes accepted to have direct effect in national law'.[81]

VI. SUMMARY OBSERVATIONS

From a GATS perspective, it is difficult to identify common features among the various health-related services. While health insurance is among the most frequently committed sectors, medical and hospital services are at the bottom of the 'league'. And this gap may further widen if current Doha Round offers were to be implemented. If there is an element of commonality among virtually all service sectors, however, it is the absence of WTO-negotiated liberalization, apart from some sector- and country-specific exceptions (telecommunications and recent WTO accession cases).

Nonetheless, there might be instances where governments have assumed ambitious commitments that go beyond existing and/or envisaged policy regimes. Such 'over-commitments' are more likely to have been scheduled in the early days of the GATS, out of ignorance and inexperience, than during later accessions. Potential candidates for over-commitments include discriminatory subsidies, in particular with regard to modes 1 and 2, and the non-exclusion, where appropriate, of public sector segments under relevant modes. A second source of uncertainty are policy changes in later years that contravene existing commitments, possibly including the extension of mandatory public insurance schemes to hitherto commercially organized segments. However, in such socially sensitive areas, affected Members may hesitate to launch challenges under the GATS, given the existence of 'soft spots' in their own regimes. In the event of successful complaints, nevertheless, the countries concerned are likely to prefer compensatory new commitments in less sensitive sectors to the restoration of the initially committed regimes.

Governments' widespread hesitation to schedule at least current levels of access under the GATS may come at a cost: International investors may be more reluctant than otherwise to transfer resources and the associated skills and expertise. Yet, very many countries have insured themselves against such effects as far as mode 3 (commercial presence) is concerned. Under most bilateral investment treaties, foreign suppliers, once established, are entitled to full national treatment, combined with some additional guarantees for which no equivalents exist under the GATS, such as compensation for expropriation. Yet, the 'BIT insurance' is not for free. Some 120 arbitration cases in service sectors, since 1995, testify to investors' resolve to defend their interests under such treaties - and the main targets are developing countries, which account for 90 per cent of the cases.

It is almost inevitable, in conclusion, to note an apparent lack of consistency and cross-coordination within governments. This problem is possibly most serious when it comes to bilateral policies or policy accords on specific issues, which may go unnoticed by the government entities that are not immediately involved. Thus, investment treaties are typically prepared by Ministries of Finance, probably without much inter-ministerial coordination, despite the treaties' broad policy impact. Preferential trade agreements are normally approached from a different, less technical angle. Given their stronger (foreign-)policy connotations, they are often promoted jointly by Foreign Ministers and Heads of Government on particular occasions. WTO-related negotiations combine such connotations with potentially significant economic and social effects and, partly as a result, tend to draw far more attention. It might be impossible to find ministers, parliamentarians or potentially affected 'stakeholders' (producers and consumers) who are unaware of these negotiations and do not seek to exert influence. If only the same standards of transparency and scrutiny were applied across the board...

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[81] Van Damme (2009) at 176. These observations were tempered by references to areas of convergence between investment and trade law. The non-discrimination principle was mentioned in this context.

ANNEX

Main disciplines: Investment treaties versus the GATS

Investment treaties	Potential equivalent under the GATS	Comments
MFN treatment	Art. II (MFN)	A number of BITs extend MFN obligation to benefits granted under PTAs.
National treatment	Art. XVII (national treatment) [SC] Art. XVI:2(e) - (f) (joint venture requirements, foreign equity ceilings) [SC]	Scope of BIT obligation depends on the standard of 'likeness' used to compare foreign and domestic investors.
Fair and equitable treatment		
Transparency	Art. III:1 (domestic publication) Art. III.3 (notification to WTO) [CON] Art. IV:2 (contact points for suppliers)	Elements of fair and equitable treatment are dispersed over various GATS provisions. Substantial coverage may not differ significantly.
Procedural fairness and due process	Art. VI:1 (reasonable, objective & impartial administration of measures) [CON] Art. VI:2 (access to judicial mechanisms) Art. VI:5 (domestic regulatory disciplines) [CON]	
Absence of arbitrary or discriminatory conduct - Good faith	Art. VI:1 (reasonable, objective & impartial administration of measures) [CON] Art. VI:5 (domestic regulatory disciplines) [CON]	
Free transfer of funds	Art. XI:1 (current transactions) [CON] Arts. XI:2, XVII (capital transactions) [SC] footnote 8 to Art. XVI (capital transfers that are an essential part of a service) [SC]	No significant differences if sectors have been scheduled under the GATS without relevant limitations.
Expropriation		
Due process	Art. VI:1 (reasonable, objective and impartial administration of measures) [CON] Art. VI:2 (access to judicial mechanisms)	GATS Art. XVI may capture expropriations that limit the number of service suppliers. However, BIT disciplines seem to be stronger in general.
Compensation	No direct equivalent. Possibly captured by Art. XVII (national treatment) [SC] and Art. VI:1 (reasonable, objective & impartial administration of measures) [CON]	
Non-discrimination	Art. VI:1 (reasonable, objective & impartial administration of measures) [CON] Art. XVII (national treatment) [SC]	
Public purpose requirement	Art. XIV (exception for measures necessary to maintain public order)	
Absence of performance requirements	Art. XVII (national treatment) [SC] Possibly Art. XVI:2(b) (market access) [SC]	
Government procurement National treatment for foreign companies	None. Arts. II, XVI, XVII are not applicable. However, some 30 WTO Members have assumed obligations under the 'Understanding on Commitments in Financial Services'.	BIT disciplines are not 'multilateralized' via GATS Art. II.
Dispute Settlement		
State-to-State	Art. XXIII (dispute settlement) WTO Dispute Settlement Understanding	
Investor - State	None	

Note: Unlike the GATS, the coverage of investment treaties extends to minority investments as well.
[CON] Conditional on existence of specific commitments.
[SC] According to the terms, conditions and qualifications provided for in the schedule of specific commitments.
Source: Adlung and Molinuevo (2008) at 13f.

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