

Trading Health Care Away?

GATS, Public Services and Privatisation

THE CORNER HOUSE

Amid the shouts of demonstrators, the protests of Southern delegations and the disagreements between the US and European Union, the World Trade Organisation (WTO) failed to launch a comprehensive revision of international trade rules in November 1999 in Seattle, USA. But talks have since begun to change one of the 28 agreements overseen by the WTO – the General Agreement on Trade in Services or GATS.¹

The US, EU, Japan and Canada are trying to revise GATS so that it could be used to overturn almost any legislation governing services from national to local level. Domestic policy making, even on matters such as shop opening hours or the height and location of new buildings, could, in effect, be turned over to the WTO. All legislation would primarily be aimed at increasing trade.

Particularly under threat from GATS are public services – health care, education, energy, water and sanitation, for instance. All of these are already coming under the control of the commercial sector as a result of privatisation, structural adjustment and reductions in public spending. A revised GATS could give the commercial sector further access and could make existing privatisations effectively irreversible. Experience in the United States and several Latin American countries, where health services have been run for profit over the past decade or so, suggests that the result will be a decline in accessibility to health care worldwide.

Most elected officials and civil servants, let along the general public, are not aware of GATS, nor of its implications. But several countries are demanding that a wide-ranging assessment of the impact of a free market in services be carried out before any more so-called trade barriers are removed. And non-government organisations (NGOs) and trade unions are demanding that services in the public interest be clearly exempt from GATS.

Rules governing international trade are certainly necessary. But such rules should place people before the entrenchment of corporate power.

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This briefing outlines the growth in services in recent years, the main provisions of GATS, the proposed revisions to the Agreement, and some key corporate aims in extending it. It details how public services may not in fact be excluded from GATS and explores the implications for public health care. It also considers what may happen to publicly-provided and -funded health care services if private companies capture their most profitable components and the public money subsidising them.

Everything Under the Sun

Heart surgery and electricity transmission, education and childcare, water purification and pesticide application, sewerage and sports centres, road construction and film making, toxic waste disposal and mobile 'phone communication – all are services, not tangible commodities. Some services are luxuries, such as tourism and entertainment. Others are essential: health care, education, transport, water and energy.

Services have become an important part of many countries' economies, overtaking manufactured goods in significance in some places.

The World Trade Organisation

The 1986-94 Uruguay Round of GATT, the widest-ranging multilateral trade agreement ever negotiated, covered for the first time not only services but also agriculture, investments and intellectual property rights, such as patents, trademarks and copyright. The 28 agreements which now come under the WTO fall into six broad categories:

- I Multilateral Agreement on Trade in Goods
- II General Agreement on Trade in Services (GATS)
- III Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPs)
- IV Understanding on Rules and Procedures Governing the Settlement of Disputes (DSU)
- V Trade Policy Review Mechanism (TPRM)
- VI Plurilateral Trade Agreements

The first category governing trade in goods contains the largest number of agreements:

1. General Agreement on Tariffs and Trade (GATT) (8 agreements modifying the original GATT), whose mandate is to eliminate tariff and non-tariff barriers to the movement of capital and goods between countries.
2. Agreement on Agriculture (AoA).
3. Agreement on the Application of Sanitary and Phytosanitary Measures (SPM).
4. Agreement on Textiles and Clothing.

5. Agreement on Technical Barriers to Trade (TBT).
6. Agreement on Trade-Related Investment Measures (TRIMs).
7. Agreement on the Implementation of Article VI of the GATT 1994 (anti-dumping).
8. Agreement on the Implementation of Article VII of the GATT 1994 (customs valuation).
9. Agreement on Preshipment Inspection.
10. Agreement on Rules of Origin.
11. Agreement on Import Licensing Procedures.
12. Agreement on Subsidies and Countervailing Measures.
13. Agreement on Safeguards.

A WTO member has to abide by all the agreements which fall into the first five categories. It can choose, however, whether to sign any of the four plurilateral trade agreements which make up the sixth category:

1. Agreement on Trade in Civil Aircraft
2. Agreement on Government Procurement
3. International Dairy Agreement
4. International Bovine Meat Agreement

The WTO administers and implements the various agreements, acts as a forum for multilateral trade negotiations, resolves trade disputes, oversees national trade policies and cooperates with other international institutions involved in global economic policy-making.

When the WTO came into effect on 1 January 1995, 76 countries became members. By May 2001, membership had almost doubled to 141 countries. The largest financial contributor to the WTO is the US, which pays about 16 per cent of its budget.

Disputes between two countries are brought by governments before tribunals of three trade bureaucrats which hear the cases in secret. If a WTO dispute (and appeal) panel decides that a country's rules are contrary to a WTO agreement, that country has to conform to the WTO requirement, pay permanent compensation to the country which brought the case, or face trade sanctions.

The procedures promote the least trade-restrictive regulation – voluntary rather than compulsory, consumer information rather than bans, and individual rather than public responsibility.

The WTO's legislative and judicial power to challenge the laws, policies and programmes of countries that do not conform to all its agreements, particularly if they are regarded as too "trade restrictive", sets the WTO apart from other international agreements.

Source: Griesgraber, J.M. and Gunter, B.G., (eds.) *World Trade: Toward Fair and Free Trade in the Twenty-first Century*, Pluto Press, London, 1997.

Providing services (excluding public services) now represents over 60 per cent of the GDP of industrialised countries and 50 per cent of that of others.² Most services are provided and consumed domestically. In Europe:

“The service sector accounts for two-thirds of the [European] Union’s economy and jobs, almost a quarter of the EU’s total exports and a half of all foreign investment flowing from the Union to other parts of the world”.³

The US Coalition of Service Industries estimates that services account for four-fifths of US GDP.⁴

International trade in commercial services was worth US \$1.35 trillion in 1999 – about one-quarter of the global trade in goods – up from some \$400 billion in 1985 and from \$1.2 trillion in 1995.⁵ This trade is firmly in the grip of the industrialised countries, which exported nearly 71 per cent of services traded internationally in 1997 and imported 67 per cent.

The EU regards itself as the biggest services exporter in the world,⁶ while more than one-third of US economic growth over the past five years has been due to exports of services.⁷ The largest single US export industry is entertainment, in particular, films and television programmes.⁸

Services account for 60 per cent, or US\$210 billion, of annual foreign direct investment, much of which is connected with privatisation of state entities.⁹

Developing countries import and export less than one-third of the services traded internationally.¹⁰ Because of the vast differences between the capacities of developed and developing countries to supply services, it is major traders in the industrialised world which have most to gain from increased access to services markets. The US Coalition of Service Industries is confident that any increase in the consumption of services anywhere in the world effectively means an increase in consumption of US services.¹¹ The European Union acknowledges the disparity in financial services:

“In many instances we will be interested in exporting our competitive banking activities to developing countries but they will not be as interested in establishing a bank in the European Community since the market is already highly competitive”.¹²

The EU attributes “the fact that services represent a smaller proportion of the economy in developing countries . . . to their lesser developed financial and business service sectors”.¹³

The world’s largest employer is tourism, accounting for one in ten workers worldwide and for one-third per cent of global services exports.¹⁴ Many of the workers in service industries are low-paid women. Some 80 per cent of women workers in the European Union are employed in services.¹⁵

General Agreement on Trade in Services (GATS)

Services first came under the rules of the world trading system in 1995 when the WTO came into effect.¹⁶ The ambitious and ambiguous General Agreement on Trade in Services (GATS) sets out rules governing international trade in practically all services.¹⁷ It does not define what it means by a service, instead offering a classification list of 160 of them based on a United Nations system which, according to Canadian

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US and EU Service Exports

- **Travel and tourism** contributed over \$25 billion to the US trade surplus in service exports over imports in 1997, the largest sectoral contribution to the overall services surplus. The European Union is the main source and the main destination of international tourist flows.
- In 1997, the US exported more than \$21 billion in **business, professional and technical services** (including accounting, legal, engineering, architectural and consulting services) and had a \$16 billion trade surplus, excluding substantial earnings from foreign investments and foreign affiliates. US legal services exports approach \$1.0 billion. US law firms produce services exports when billing foreign clients.
- The global **telecommunications** services market is estimated at over US\$725 billion. The EU, a net exporter of telecommunications services, has a 28 per cent share of total world telecom revenues. US revenues are expected to increase at about 20 per cent annually for the next five years for outbound calls from the US to foreign markets. The WTO estimates that sales over the Internet will double each year for the next five years.
- The US **asset management** industry is the largest in the world, handling billions of dollars of private investments and funds each year. By the year 2002, an estimated 51 per cent of total US asset management revenue of \$160 billion will come from outside the US. Today, US-domiciled investment managers manage 14 per cent of the total of non-US retirement plan assets and 5 per cent of non-US mutual fund assets.
- Foreign students, after scholarship and local assistance, spend some \$8 billion in the US. The US has a surplus in trade in **education** services of \$7.0 billion.
- **Medical** services rendered in the US to foreign citizens produced an export surplus of \$0.5 billion.
- The **energy** industry – which accounts for about 7 per cent of US GDP – is pressing for global trading rules against monopoly power, anti-competitive practices and discrimination against new market entrants, such as US companies.
- Some 160 US and EU **construction** firms account for 85 per cent of the world market for construction projects, the US taking 49 per cent and the EU 36 per cent. The EU is a major market for US firms, while EU firms are strong in Africa, the Middle East and Asia. Construction accounts for up to 10 per cent of GDP in industrialised countries but much less in developing countries.

Sources: Statement of Robert Vastine, Coalition of Service Industries, 21 October 1999; "Opening World Markets for Services: A Guide to the GATS: Which Sectors Are Covered by GATS?", website: <http://gats-info.eu.int/gats-info/guide.pl?MENU=c c c>

researcher and activist Scott Sinclair, "reads like a catalogue of occupations and human needs".¹⁸ The classification makes no distinction between public (or voluntary) services and those provided on a for-profit basis. Because distribution is a service, moreover, GATS also encompasses goods. As the EU says, "Goods cannot walk, they need to be distributed and transported".¹⁹

Because the main way of governing services has traditionally been via complex national rules and regulations, GATS is also "fiendishly complex".²⁰ Like the GATT agreement before it covering trade in goods, GATS encourages trade across national borders in services by requiring a WTO member country to treat all countries the same (most-favoured nation) and to treat foreign companies as if they were domestic (national treatment).

But GATS differs from the agreement governing international trade in goods in several critical ways. At present, some of its rules and requirements do not apply to all services, but only to those sectors which each country has indicated it is prepared to open up to foreign competition.

Moreover, whereas trade in goods involves simply transporting products from one country to another (cross-border trade), trade in services is more varied because services are not so tangible or physical. Airlines, telephone companies, banks and accountants all provide their services in different ways. Thus GATS lists another three ways (or "modes") in which services can be supplied besides cross-border supply – movement of consumers, foreign commercial presence and movement of persons – because "the supply of many services is possible only through the simultaneous physical presence of both producer and consumer".²¹ Some services can be supplied in several ways, others not. A business

adviser, for instance, can supply her services to a client in another country by mail, by the client visiting her, through an office in the client's country or by visiting the client. To be a tourist, someone has to go to another country to consume tourism-related services, as does an "exported" street cleaner to carry out "environmental services". A government thus provides the WTO with a "schedule of specific commitments" listing which services and the ways of supplying that service it is prepared to open up to competition under GATS (*see* Box, p.6).²²

The majority of the WTO's 141 member countries have so far committed themselves to liberalising just a small part of their services. Most commitments have been made in tourism, hotels and restaurants, computer-related services and value-added telecommunications. The least number of concessions have been made in river transportation, basic telecommunications, recreational and cultural services, education and postal services.

A country can alter a commitment but has to wait three years after it has listed it before it can do so. The country also has to negotiate a substitute commitment as compensation in a way which satisfies all other WTO members. The WTO Secretariat admits that country commitments undertaken in GATS "have the effect of protecting liberalization policies, regardless of their underlying rationale, from slippages and reversals".²³ The former WTO Services Division Director, David Hartridge, said that GATS "can and will speed up the process of liberalisation and reform, and make it irreversible".²⁴ India's former ambassador to GATT, Bhagirath Lal Das, stresses that liberalisation under GATS is different from a country undertaking liberalisation on its own without making a binding commitment to the WTO:

"The developing countries have lost the flexibility of modifying their policy in the light of future experience . . . even if it is assumed that they benefit by importing services."²⁵

The power of GATS, as with all WTO agreements, is that its rules can be enforced by trade sanctions (*see* Box, p.2). GATS does allow countries to protect human, animal and plant life or health (Article XIV) through measures which might otherwise contravene the Agreement, but its preamble, according to the US Alliance for Democracy, "has a caveat large enough to drive a truck through".²⁶ WTO dispute panels have interpreted exemptions and exclusions narrowly and forcefully in favour of trade in GATT disputes and have usually ruled against environmental protection measures.²⁷ These rulings "show that GATS can be used to challenge an almost unlimited range of government regulatory measures that, even indirectly or unintentionally, affect the conditions of competition of international service suppliers".²⁸

The GATS standard for "national treatment", for instance, extends well beyond conventional notions of non-discrimination between domestic and foreign companies. It applies to any measure from any level of government – national, provincial, state, regional, municipal or local – that alters the conditions of competition in any way that might disadvantage a foreign service or supplier. The WTO's Council for Trade in Services (the permanent body responsible for GATS) has discussed restrictions on large-scale retail outlets, shop opening hours, zoning and planning laws, controls on land use, building regulations, building permits, registration of contractors and professionals, regulation of professional fees, environmental regulations, worker health and safety regulations, local content and employment policies, urban planning rules and environmental protection policies. Even legislation to ensure that

GATS could be used to challenge almost any government regulatory measure affecting competition between international service suppliers.

GATS could speed up service liberalisation and make it irreversible.

GATS Main Obligations

Trade in services used to be considered ancillary to manufacturing and trade in goods. In the mid-1980s, however, many Western governments, faced with worldwide recession, inflation and unemployment, decided that removing obstacles to international trade in services, particularly national regulations, could increase the momentum to export services.

The US thus pushed for the provisions of the agreements governing trade in goods to be transposed into the area of services as a whole (although financial services were of prime interest), a move which "could easily have sunk the Uruguay Round and crippled the GATT", according to current WIO Director-General Mike Moore. Many countries reluctantly agreed to GATS only if they could choose which of their services were covered by the Agreement. The US took care, however, to include clauses mandating further liberalisation in future.

All Services

Two GATS obligations apply directly and automatically to all WTO members for all services – most-favoured-nation treatment and transparency.

- **Most-favoured-nation (MFN) treatment** (Article II) does not mean one country is preferred over another – it means the opposite. Favour one, favour all. Treat all countries the same.

If a WTO member country grants favourable treatment to another country (even a non-WTO member) regarding the import of a service, it must grant all other WTO signatories the same treatment. If a country allows any foreign competition in a service sector, it must allow service providers from all WTO member countries to compete to supply that service.

A country could list any exemptions to this MFN principle by 1995, but exemptions were to be reviewed after five years and could not last more than 10 years anyway. The WTO interprets this MFN obligation as prohibiting not

only *de jure* discrimination (discrimination specifically set out in regulations) but also *de facto* discrimination (discrimination resulting from regulations or measures not formally discriminatory).

- **Transparency** (Article III) requires governments to publish all relevant laws and regulations governing all service sectors. By 1997, governments should have set up enquiry points for foreign companies and governments to obtain this information.

Specified Services

The other two GATS obligations, market access and national treatment, apply only to those services which a country lists in its Schedule of Specific Commitments.

- **Market access** (Article XVI) allows foreign companies to provide cross-border services in a country. But a country can restrict such access by limiting the number of suppliers, operations or employees in a specific sector; the value of transactions or assets; the legal form of the supplier (for instance, limiting it to a branch or joint venture); or the participation of foreign capital.

- **National treatment** (Article XVII) means that once foreign companies have been permitted to enter a country, they must be treated in the same way as domestic ones. The WTO explains that "the key requirement is to abstain from measures which are liable to modify, in law or in fact, the conditions of competition in favour of a Member's own service industry". Thus the test for non-discrimination is whether any measure puts a foreign supplier at a disadvantage.

Modes of Supply

The Schedule of Specific Commitments also identifies which of four different ways (or "modes") of supplying services are covered.

- **Cross-border supply** (Article I.2a). Services can be supplied from one country to another: international telephone calls; Internet services; telemedicine; a purchase of laboratory services from another country;

a purchase of medicines or advice on the Internet. Only the service itself crosses the border.

- **Consumption abroad** (Article I.2b). Individuals or companies can go to another country to use a service there. Tourism is a prime example. This mode encompasses travel to another country to obtain a medical treatment that is better, faster or cheaper than that available domestically.

- **Commercial presence** (Article I.2c). A company can set up subsidiaries, branches, joint ventures or representative offices or can lease premises in another country to provide services there. For instance, banks can set up operations in another country, and US health care companies can set up hospitals or clinics in European countries.

- **The presence of natural persons** (Article I.2d). Individuals from one country can be admitted temporarily to another country to provide services there, for instance, fashion models, doctors or nurses. GATS does not apply, however, to people seeking permanent employment or to conditions for obtaining citizenship, permanent residence or permanent employment. Of all four ways of supplying a service, WTO member countries have made the least number of commitments in this mode.

Once a government has committed itself under GATS to opening a service sector to foreign competition, it must not keep money from being transferred out of the country to pay for the relevant services (Article XI), except when the country is experiencing serious balance-of-payment difficulties (Article XII). Such exceptions must be temporary and justified by an International Monetary Fund assessment of the country's financial situation.

GATS thus provides almost guaranteed conditions for foreign exporters and importers of services and investors in any sector which a country has listed in its Schedule.

a country benefits from foreign investment – minimum number of local jobs or content, for instance – could be considered trade restrictive.²⁹ No government measure or practice, whatever its aim, is beyond GATS scrutiny if it might affect trade in services. Countries could thus use GATS to “frustrate government policies, practices and programs that allegedly adversely affect foreign commercial interests in services”.³⁰

David Hartridge, WTO’s former director of services, described GATS as “the first multilateral agreement to provide legally enforceable rights to trade in all services” and “the world’s first multilateral agreement on investment, since it covers . . . every possible means of supplying a service, including the right to set up a commercial presence in the export market.”³¹ According to the EU, GATS “aims to end arbitrary regulatory intervention, and assure predictability of laws, to generate growth in trade and investment”.³²

Unsurprisingly, critics call GATS “the MAI in disguise”. According to them, rules and disciplines with effects similar to those of the abandoned Multilateral Agreement on Investment are being incorporated in the WTO through the back door.³³ The former WTO Director-General, Renato Ruggiero, acknowledged in 1998 that GATS extended into “areas never before recognised as trade policy” and warned that “neither governments nor industries have yet appreciated the full scope of these guarantees or the full value of existing commitments”.³⁴

Researcher Scott Sinclair says that GATS “is designed to facilitate international business by constraining democratic governance”.³⁵ Indeed, the WTO expressly states that the Agreement will help its members overcome “domestic resistance to change” and that it will facilitate “more ambitious reforms . . . than would be attainable on a national basis alone”.³⁶

GATS 2000

GATS is innovative, complex and without legal precedent. Few of its provisions have been tested or clarified by challenges brought to the WTO dispute panel. Little information exists on the impact of GATS so far in facilitating trade in services, or on the economic benefits countries have accrued from services liberalisation, let alone their social and environmental effects. There is little baseline data upon which to make comparisons. The WTO Secretariat recognises this lack of data upon which to base an assessment of trade in services, while the UK government says it has yet to work out how such statistics can even be collected.³⁷ Nonetheless, WTO representatives have begun to negotiate to extend the scope of GATS.

When the Agreement was signed in 1995, some countries considered it to be incomplete.³⁸ A clause (Article XIX) was therefore included mandating “successive rounds of negotiations . . . aimed at achieving a progressively higher level of liberalization” – in practice, privatisation and deregulation. It specifies that the first “successive round” of negotiation should begin within five years of GATS coming into effect, that is, by the year 2000. As Canadian trade and investment researcher Ellen Gould points out, “under the GATS, liberalization could just keep on going and going, presumably until negotiators run out of sectors to open up to foreign competition and ownership”.³⁹ The WTO Secretariat describes Article XIX as “a guarantee that the present GATS package is only the first fruit of a continuing enterprise.”⁴⁰ Other clauses

GATS is the first multilateral, legally-enforceable agreement covering trade and investment in services.

GATS mandates successive rounds of negotiations to achieve more and more liberalisation – in practice, privatisation and deregulation.

Regulating Governments, Not Corporations

Article VI of GATS covers domestic regulation. Its aim is to encompass any regulation that affects services but which is not covered by other GATS obligations.

Its fourth clause aims to ensure that "qualification requirements and procedures, technical standards and licensing requirements do not constitute unnecessary barriers to trade in services".

Although undefined in GATS, "technical standards" could encompass most types of government control. The WTO Agreement on Technical Barriers to Trade, for instance, defines them as:

"product characteristics or their related processes and production methods, including the applicable administrative provisions, with which compliance is mandatory".

In the context of services, "technical standards" could apply to the processes and methods of producing services, including administration. This could encompass their funding and delivery, including reimbursement under mandatory (public or private) insurance schemes.

A wide swathe of government regulations concerning environmental protection, consumer protection and industrial policy would seem to be covered by this fourth clause: legislation accrediting professionals as competent to practise; awarding licences to television or radio stations; giving university status to academic institutions; licensing hospitals; and granting waste disposal permits.

So that these national requirements and standards do not constitute an "unnecessary barrier" to trade in services, Article VI.4 states that they should be "not more burdensome than necessary" and should not restrict the supply of the service. But what does "burdensome" mean? How would restriction be determined? In case of a dispute between countries, the clause does not provide a clear legal formula that a WTO dispute panel could refer to.

A Working Party on Domestic Regulation – one of the three sub-groups of the Council for Trade in Services (the body within the WTO that oversees GATS) – has been drawn up to discuss "reform"

of domestic regulation. This involves drafting a "necessity test" – a legal formula which could be used "to assess the level of trade-restrictiveness of a measure".

If proposals for this test are adopted, a government challenged by another through the WTO would first have to show that a disputed regulation met a "legitimate objective" – and the WTO would determine what counted as "legitimate".

Then, to clarify "burdensome" and "restrictive" as applied to the means of achieving that objective, the Working Party has considered importing into Article VI.4 the definition of "least burdensome" from a GATS Annex on Telecommunications: "pro-competitive".

The European Union has gone further and identified "anti-competitive practices", including cross-subsidising by monopoly providers of network infrastructure and services. It argues that this practice restricts competing suppliers from being able to provide services in a market. Instead, it maintains that charges for each part of a service should be at:

"cost-oriented rates that are transparent, reasonable, having regard to economic feasibility, and sufficiently unbundled so that the supplier need not pay for network components or facilities that it does not require for the service to be provided".

Governments that currently use non-market mechanisms, such as risk pooling, social insurance funds, block contracts and cross-subsidising, to deliver public services to as much of their population as possible could find such practices challenged as anti-competitive (see p.19).

The European Union has also suggested that a measure should not be considered trade-restrictive if it is "proportionate" to the objective pursued. But what might be considered proportionate, reasonable or rational would be a matter of judgement, reflecting the values of those with decision-making power.

Worse, Article VI.4 could be interpreted as applying to *all* services, not just to those which a country has offered to liberalise. The other clauses in Article VI clearly apply only to those services listed in a country's schedule of commitments. The WTO Secretariat believes the different phrasing of Article VI.4 is "intentional".

If these proposals were adopted, all domestic regulations would have to be "pro-competitive", even if no foreign firm was involved. A WTO disputes panel could require countries to unbundle a public monopoly such as health care and substitute competing service providers or competing health care insurers. Health systems researchers Allyson Pollock and David Price point out that these proposals "would transform the WTO from a body combating protectionism to a global agent of privatisation".

"The WTO's strategy is shifting from persuasion to the development of new global regulations which will over-ride national sovereignty in domestic policy and impose unprecedented market reform obligations on all the processes of service delivery and throughout all service sectors".

In essence, the aim of GATS is to regulate governments, not corporations. Compared to markets in goods, those in services and access to them are more constrained by government interventions. The power of a GATS article on domestic regulation clause is that many governments may censor themselves by not instituting legislation or public policy objectives which could be interpreted as being against WTO rules. There has been no challenge to any domestic regulation under GATS as yet, but at the WTO Secretariat itself acknowledges, "cases may arise in the future". GATS sets in place a legal framework which governments could use in future to challenge other countries' domestic regulations.

The WTO stresses that governments can still regulate under GATS. Discussions about domestic regulation, however, raise the question: how?

Sources: Pollock, A.M. and Price, D., "Rewriting the Regulations", *The Lancet*, 356, 9 Dec. 1999, pp.1995-2000; "Opening World Markets for Services: A Guide to the GATS: Which Sectors are Covered by GATS?", website: <http://gats-into.eu.int/>; Sinclair, S., *GATS: How the World Trade Organization's New "Services" Negotiations Threaten Democracy*, Canadian Centre for Policy Alternatives, Ottawa, 2000; WTO Secretariat, "International Regulatory Initiatives in Services", S/C/W/97, 1 March 1999.

provide for further rules to be developed for domestic regulation, government procurement of services, subsidies and emergency safeguards (*see* Boxes, p.8 and p.10).

When he was European Commission Vice President, Leon Brittan made clear that “the aim [of GATS 2000 negotiations] must be . . . to conclude an ambitious package of additional liberalisation by developing as well as developed countries, in politically difficult as well as in other sectors”.⁴¹ The EU Commissioner for Trade, Pascal Lamy, has argued that “if we want to improve our own access to foreign markets, then we can’t keep our protected areas out of the sunlight. We have to be open about negotiating them all if we are going to have the material for a big deal.”⁴²

The US, European Union, Japan and Canada (known as the Quadri-lateral or “Quad” governments) are pushing hard to:

- increase the services and ways of supplying services that WTO member countries agree to open up to foreign competition (market access);
- re-classify services to get around some countries’ reluctance to open them up to foreign competition;⁴³
- insert new rules and restrictions that apply to *all* members, services, sectors of services and ways in which services are supplied, irrespective of whether countries have agreed to open such services to competition;⁴⁴
- place new constraints on domestic regulation (*see* Box, p.8).

They are seeking more access to Southern markets, to each other’s public services, and further deregulation of services already in private hands but publicly-regulated, such as media, publishing, telecommunications, energy, transport, financial and postal services. Northern countries are interested in service liberalisation in Southern countries in construction and engineering; distribution; education; environmental, health and social services; and recreational and cultural services.

These revisions, if they are agreed upon, could mean that the voluntary nature of GATS – under which a country decides which services to list as open to foreign competition – would in effect be meaningless. It could be irrelevant whether a country offers up its services or not if other rules apply to *all* services. Guarantees, such as those from the UK’s Department of Trade and Industry that “the UK government has no intention whatsoever of offering to privatise public health care or education under the GATS 2000 negotiations”, would have little force.⁴⁵

Following the GATS “built-in agenda” mandating successive rounds of negotiations, talks opened on 25 February 2000 in Geneva, home to WTO headquarters. The United States would like these negotiations to be completed as soon as possible, and suggested the end of the year 2002 as a deadline. Other countries, however, want the negotiations to be open-ended, or integrated within a broader and comprehensive revision of all the WTO agreements.⁴⁶

Despite the requirement for “transparency” in GATS (*see* Box, p.6), the renegotiations are taking place between government representatives behind closed doors (but in close consultation with international corporate lobbyists). Few of the results of discussions are made publicly available by the WTO or individual countries. It is next to impossible for citizens’ organisations to find out the current state of negotiations while access to many background documents is restricted.⁴⁷ Thus even negotiations on apparently technical issues such as reclassification of services are evading public accountability and public and parliamentary debate.

A revised GATS could threaten domestic and international regulation aimed at providing public services for all and protecting the environment.

Proposed revisions could mean that the voluntary nature of GATS would be meaningless.

Business Objectives in GATS 2000

This secrecy, combined with GATS's obscure, bureaucratic, arcane and technical terminology, make it difficult for policymakers, let alone the general public, to grasp the significance of the Agreement. But statements from US and EU industry associations indicating what they want out of the current negotiations give a much clearer picture.

The president of the US Coalition of Service Industries (CSI), Robert Vastine, has said that his "most salient criticism" of GATS is that

GATS 2000 Negotiations—New Rules and Restrictions

GATS mandates specific rules to be drawn up covering subsidies, government procurement and emergency safeguard measures.

- GATS already covers **subsidies** in effect as part of the national treatment and most-favoured nation provisions. If a government provides a subsidy to a national service supplier (including a public one), in theory, it has to provide it to a foreign-based service supplier as well. As WTO research staff have said, this requirement is a powerful argument for abandoning the subsidy altogether. In practice, it would eliminate public services and encourage privatisation.

Article XV, however, promises to develop further rules on subsidies to avoid "trade distortive effects" and as such goes further than previous international free trade agreements such as the earlier GATT or the North American Free Trade Agreement (NAFTA). The Article sets no date for these negotiations.

Further rules could, however, be drawn up to protect national subsidies and grants related to the provision of universal public services such as health care and education or to public interest objectives such as health and safety.

- For the most part, **government procurement** – government agencies buying in goods and services for governmental purposes – falls outside WTO obligations. GATS Article XIII currently exempts it from the most-favoured nation, national treatment and market access obligations (but not transparency), but mandates further negotiations by the beginning of 1998.

Negotiations on government procurement are taking place in

other WTO fora, however. For instance, the Council for Trade on Goods is trying to negotiate an agreement on transparency as part of the separate Agreement on Government Procurement which would apply to services as well as goods. The plurilateral Agreement currently covers goods only and has been signed by just 27 (mainly industrialised) countries.

The US has been pushing hard for an agreement on transparency. It wants binding rules on the notification and announcement of tenders for government procurement contracts in order to give companies enough information and time to submit bids.

Reform of government procurement could be another mechanism by which public services are opened up to competition. GATS does not define "governmental purposes". The WTO Secretariat has stated that the mandated negotiations "are expected to lead to commitments to open up some government purchases to foreign service suppliers."

- **Safeguards** are emergency measures taken by a government to provide temporary protection against "fairly traded" products that either cause or threaten to cause "serious injury" to domestic service suppliers, for instance, if the domestic market has been flooded with these products, or if the country has a balance of payments crisis. They are permitted under the GATT rules on goods, but have not yet been introduced into GATS. "Serious" has not been defined.

GATS Article X provides for negotiations on emergency safeguard measures to be completed by the beginning of 1998, a deadline which the Working Party on GATS Rules agreed to extend to December 2000 and then again to March 2002.

Southern countries argue that

safeguards rules would address concerns about the difficulty of reversing GATS commitments. Many countries are seeking means by which they might, at least temporarily, suspend GATS commitments when faced with adjustment problems or until their domestic industries have developed to the extent that they can withstand foreign competition.

Citizen groups in both North and South are concerned to keep environmental, health and safety, and consumer measures, to limit commercial encroachment on public services, and to reverse commercialisation if it proves harmful. Indeed, such safeguards could be part of a process to reform GATS so that it was less detrimental to sustainable development or human health.

But Northern country negotiators have strongly resisted safeguard provisions, contending that GATS provides enough flexibility already.

Negotiations on these rules are proceeding in parallel with those on market access (that is, increased country commitments on their schedules) and could be used as trade-offs between the two. For instance, the prospect of an emergency safeguard mechanism might be used to persuade Southern countries to make more commitments.

Sources: "Opening World Markets for Services: A Guide to the GATS: Which Sectors are Covered by GATS?", website: <http://gats-into.eu.int/gats-info/guide.pl?MENU=ccc>, accessed 1 November 2000; Sinclair, S., "Expanding the WTO Services Agreement: What's on the GATS 2000 Re-negotiating Table?", *GATS: How the World Trade Organization's New "Services" Negotiations Threaten Democracy*, Canadian Centre for Policy Alternatives, Ottawa, 2000, ch 4.

countries have specified so few services to be opened up to liberalisation.⁴⁸ He argues that:

“the new negotiations must secure commitments to national treatment, market access, and cross border services in as many sectors as possible. Current scheduled exceptions are too broad, and must be honed”.⁴⁹

US negotiators must:

“propose broad commitments to liberalization in areas such as the *right* to establish a business presence in foreign markets (commercial presence), the *right* to own all or a majority share of that business, and the *right* to be treated as a local business (national treatment).”⁵⁰

Vastine is adamant that the WTO:

“must . . . provide that the entire new ‘round’ be completed by 31 December 2002, in order to force closure on the existing agenda, reap what gains can be garnered, and begin again with a fresh agenda that could include items like investment”.⁵¹

The European Union has been actively reaching out to companies. It declares that:

“GATS is not just something that exists between Governments. It is first and foremost an instrument for the benefit of business, and not only for business in general, but for individual services companies wishing to export services or to invest and operate abroad.”⁵²

“In short”, it concludes, “the GATS should be one of the key reference texts used by any corporate planner seeking to do business on a world level”.⁵³

The EU encouraged the establishment in 1998 of the European Services Network (now Forum – ESF) of multinational industry representatives, led by Barclays plc chair Andrew Buxton, to “advise European Union negotiators on the key barriers and countries on which they should focus” and to ensure “that the EU’s policy corresponds to the real export and economic growth interests of our service industries”.⁵⁴ The ESF still represents a limited group of companies, primarily financial services, telecommunications, postal, tourism and engineering/construction, but is determined “to support and encourage the movement to liberalise service sector markets throughout the world and to remove trade and investment barriers for the European services sector”.⁵⁵ The ESF says that “foreign investors should have the same access to domestic markets as domestic companies” and that barriers such as nationality or residency requirements should not apply to the posting of key personnel.⁵⁶

Several joint industry-government conferences provide examples of the close collaboration between corporate employees and government officials in testing and refining their ideas for expanding GATS. In the US, one of the goals of the World Services Congress, a large three-day international conference in November 1999 attended by corporate executives and WTO, World Bank and government officials, was to “shape government policies”. The 100 or so comprehensive research papers presented at the Congress serve “as a guide not just to the topics under consideration but also to the intended direction of the GATS re-negotiation itself”.⁵⁷ In November 2000, the US Department of Commerce and the US Coalition of Service Industries jointly held a conference on “Services 2000: A Business-Government Dialogue on

Via GATS, private companies could prise open for themselves public funding for services.

US Trade Expansion Objectives”, the purpose of which was “to focus industry’s priorities in the current WTO negotiations” and to “allow participants to make detailed recommendations to negotiators”.⁵⁸ The Trade Directorate of the European Commission, meanwhile, co-funded the November 2000 European Services Forum international conference on “The GATS 2000 Negotiations: New Opportunities of Trade Liberalisation for All Services Sectors”.⁵⁹

GATS Privatisation of Immigration?

Many developing countries have pointed out that GATS contains clear, specific and detailed obligations facilitating the movement of capital, but not for the movement of labour. Yet as US sociologist Saskia Sassen notes:

“it is the increased circulation of capital, goods and information under the impact of globalization, deregulation, and privatization that has forced the question of the circulation of people onto the agenda.”

GATS encourages industrialised countries to poach the brightest and the best from poor countries and to put up barriers to the rest. Highly-skilled professionals often gravitate toward countries offering better pay and working conditions. In Jamaica, over 50 per cent of nursing positions are vacant because Jamaican nurses are working in North America. Filipino nurses also move in large numbers to the US.

India and Cuba train doctors who wind up working abroad. Indian finance minister Yashwant Sinha pointed out at the World Economic Forum in Davos in January 2001 that 38 per cent of all doctors in the US are Indians, as are 34 per cent of the scientists at NASA. For developing countries, such mobility can mean increased remittances sent back home, but also a drain of their most-needed skills. The investment these countries put into training such professionals is an example of aid flowing from South to North.

The British public health system, meanwhile, has estimated that it is short of 17,000 nurses and several thousand doctors, not least because of deteriorating pay and working conditions, and cuts in training. At least one quarter of doctors and nurses working in the public sector qualified in countries such as Spain, Scandinavia, the Philippines, Australia, New Zealand

and, recently, China. South African President Mandela appealed to Britain to stop “leaching” his country’s health workers.

This trend is largely controlled by Northern countries wanting extra skilled workers. The use of foreign labour keeps wages and conditions low. Encouraging the movement of health care professionals also creates pressure to standardise medical training and qualifications, but the pressure is often for lower standards rather than higher ones. The WTO Secretariat has said that:

“the most significant benefits from trade are unlikely to arise from the construction and operation of hospitals . . . but their staffing with more skilled, more efficient and/or less costly personnel than might be available on the domestic labour market”.

Indeed, it is professional workers who are the main focus of GATS. Sassen describes GATS as “a privatized regime for the circulation of service workers” which has not been subject to the public scrutiny applied to national immigration policy.

GATS amounts to a migration policy (albeit one applying to temporary labour) under the oversight not of a national government but a separate, autonomous entity. Sassen argues that:

“this can be seen as yet another instance of privatization of that which is profitable and manageable . . . In this case, it would be a privatizing . . . of immigration policy components that are characterized by high-value added (persons with high levels of education and/or capital), manageability (they are likely to be temporary and working in leading sectors of the economy and hence are visible migrants, subject to effective regulation), and benefits (given the new ideology of free trade and investment). Governments are left with the supervision of the ‘difficult’ and ‘low-value added’

components of immigration – poor, low-wage workers, refugees, dependants, and potentially controversial brain-drain flows. This can clearly have a strong impact on what comes to be seen as the category ‘immigrant’ with policy and broader political implications.”

“Human capital” can be imported, but borders are closed to “immigrants”, who are invariably assumed to be “black”, resulting in institutionalised and legitimised racism.

Several developing countries support GATS’ facilitation of the movement of people because, as India’s ambassador to the WTO, Srinivasan Narayanan, said, “this is an area where developing countries have some competitive advantage”. Narayanan has pointed out that Northern countries cite the “politically sensitive issue” of immigration as a reason for not making more commitments under the “presence of natural persons” way of supplying services – even though Southern countries have had to make commitments under other WTO agreements in politically sensitive areas such as intellectual property rights and cannot renege on them. Yet long-standing WTO observers point out that countries such as the US are unlikely to allow in Indian workers unreservedly.

Sources: Sassen, S., “Unstoppable Immigrants”, *The Guardian*, 12 September 2000, p.21; Sassen, S., *Globalization and Its Discontents: Essays on the New Mobility of People and Money*, The New Press (W.W.Norton & Co.), New York, 1998; Srinivasan Narayanan, statement at “The GATS 2000 Negotiations: New Opportunities of Trade Liberalisation for all Service Sectors”, European Services Forum Conference, 27 November 2000, Brussels, website: www.esf.be/esf_%20conf_speeches.htm, accessed 24 March 2001; WTO Secretariat, “Background Note on Health and Social Services”, S/C/W/50”, 18 September 1998.

Turning Public Into Private

Although GATS encompasses all services, many civil servants and government ministers believe that it makes an exception for public services – those “supplied in the exercise of governmental authority” (Article I.3b) – such as health care, education or utilities. But GATS defines government services so narrowly – “any service which is supplied neither on a commercial basis, nor in competition with one or more service suppliers” (Article I.3c) – that the exception could be almost meaningless if one country were to challenge another country’s public services at the WTO dispute panel as contravening GATS.⁶⁰

Governments the world over have been deregulating and privatising both the funding and the provision of public services, sometimes on their own initiative, sometimes as a condition of IMF structural adjustment programmes (SAPs) and sometimes on World Bank advice.⁶¹ In some cases, governments have simply sold public entities off. For instance, in Britain, the railways, telephones, and electricity, gas and water utilities have been transferred to the for-profit sector. Governments are transforming other public services, particularly those which it might be politically unacceptable to privatise outright, by requiring the public body to contract services out to for-profit companies or to institute a process of compulsory competitive tendering (private provision). They have separated infrastructure such as buildings from service provision, and privatised the infrastructure by means of an array of public-private “partnerships” that retain an ostensible public dimension and thus appear more politically acceptable. Examples include the UK’s Private Finance Initiative (PFI), build-own-transfer (BOT) schemes, and build-own-operate-and-transfer (BOOT) projects. Governments have also introduced internal markets, that is, divided purchasers from providers within a public service sector (*see* Box, pp.21-24).⁶² Management from the private sector has been introduced to infuse the public service sector with market-oriented methods and principles. As David Hall of the Public Services International Research Unit points out:

“The corporatisation of public service organizations . . . usually involves the introduction of business accounting . . . and may be a change as significant as that to private ownership itself.”⁶³

As far as GATS is concerned, if a government contracts out any part of its public services, such as cleaning or catering, or if private (either for-profit or voluntary) companies supply services also provided by the government (for instance, if private schools exist alongside state ones, or if there is a mixture of public and private funding), then those services could be judged by a WTO dispute panel as *not* being a government service and thus subject to GATS rather than exempt from it, that is, subject to competition from operators from abroad.⁶⁴

As a result of existing deregulation and privatisation, national – and increasingly transnational – companies have sprung up and made inroads into a wide range of public services in many countries, particularly utilities (water, energy, telecommunications, transport), refuse collection, prisons, housing, social services, and support services (cleaning, catering, information technology).⁶⁵ Via GATS, they could gain access to many more.

The European Union, for example, wants all WTO member countries to open up their water delivery systems to competition because this “would offer new business opportunities to European companies, as the expansion and acquisitions abroad by a number of European

Global trade rules threaten to dismantle public services such as health, education and welfare.

water companies show”.⁶⁶ French-based companies such as Vivendi, Suez-Lyonnaise and Bouygues (SAUR) have taken the lead in water supply.⁶⁷ Education has been described by investment group Lehman Brothers as “the final frontier of a number of sectors once dominated by public control”.⁶⁸ Other targets include museums, libraries, energy and transport.

Via GATS, private companies could prise open for themselves public funding for services. The EU and US spend a substantial amount of public money on public services. In the countries of the OECD

Creating Health Markets: Privatising Health Care . . .

To establish a trade in services, as GATS aims to do, there has to be a market in services – services have to be bought and sold. Until recently, however, many countries have not had markets in health care, education, water and sewerage, or energy. All have, by and large, been provided by government or non-profit organisations. The state has set up schools and paid the teachers, built the hospitals and trained the nurses and doctors.

Markets are now being created by enabling entities other than the state to provide services. Privatisation of ownership – outrightly selling-off water suppliers, for instance – is an obvious means. Other means are more hidden and gradual: privatisation of service provision (by requiring contracting out, leasing or competitive tendering); privatisation of finance (charging users of the service, private capital, private health insurance) and the introduction of internal markets (dividing purchasers from providers of services).

Health care services have not generally been explicitly privatised. Instead, there has been an incremental process of government retrenchment accompanied by private sector enlargement as the services have been commercialised. Markets – and thus the potential for trade – have crept in through the back door.

IMF and World Bank

Governments such as those in the US, Britain, Chile and New Zealand have themselves instigated the gradual commercialisation of their public health services. Others, however, have been unable to avoid doing so because of debt

and the influence of the International Monetary Fund (IMF) and the World Bank.

IMF programmes have compelled many countries to reduce their public spending on health, which is no longer regarded as a productive investment for human development and economic growth, but as an unnecessary financial burden and expense which governments should avoid.

Moreover, a “cost recovery” strategy for public services has invariably involved the introduction of “user fees” or charges to patients, even for basic health care, which are now widespread through the South. A 1998 World Bank report noted that “about 40 per cent of projects in the Bank’s [health, nutrition and population] portfolio and nearly 75 per cent of projects in sub-Saharan Africa included the establishment or expansion of user fees”. Studies have shown that such fees simply decrease people’s use of medical services. The results are often an increase in child mortality, sexually-transmitted diseases and tuberculosis (TB). People die of easily-treatable diseases because they cannot afford to buy the medicines.

In Nigeria, Kenya and Ghana, people’s use of hospitals and clinics dropped by half within one or two weeks of charges being introduced. In one region of Nigeria, maternal deaths rose 56 per cent while hospital births declined 46 per cent after user charges for emergency admissions were introduced. In Ghana, user fees in rural clinics contributed to a doubling of child mortality between 1983 and 1993. Infant mortality has risen by one quarter in Zambia since 1980, while life expectancy has dropped from 54 years to 40. In Zimbabwe, the poor were supposed to be exempt from user fees levied on health services, but a World Bank evaluation found

that just one-fifth of the poor could obtain the necessary waivers.

The World Bank has been directly involved in health policy planning in the South since the mid-1980s. Its 1993 annual report, *Investing in Health*, described public services as a barrier to the abolition of world poverty. It still maintains that “if market monopolies in public services cannot be avoided, then regulated private ownership is preferable to public ownership” and that, in most circumstances, “the primary goal of public policy should be to promote competition among providers.” The report advocated incentives for the purchase of private insurance, privatisation of public services and promotion of market competition.

The Bank’s health “reform” policy has included making people pay for their health care, reducing public provision to a few programmes, and turning over the rest of government services to profit-making organisations and individuals.

The Bank currently operates over 200 health care projects, many effectively requiring further privatisation of public health systems. The Bank’s health spending is now three times the budget of the World Health Organisation. In 1998, Mexico received the largest loan the World Bank had ever made for health care, \$750 million, to change the “structure” of public health care operations.

In the west Indian state of Maharashtra, the World Bank is providing half the funding (Rs300 million/£4.4 million) for a private hospital treating heart disease in a joint venture with one of India’s largest pharmaceutical companies, Wockhardt. Wockhardt is linking up with a large US health care insurer and with the US Harvard Medical School, which will train Wockhardt’s medical staff and introduce them to new medical technologies.

(Organisation for Economic Cooperation and Development), public expenditure on health services and education accounts for more than 13 per cent of gross domestic product.⁶⁹ Much of this spending now goes to public or voluntary bodies but could end up being channelled to for-profit groups. Nearly 50 per cent of UK tax revenue now goes to profit-making companies.⁷⁰

It is often argued that the privatisation of public services brings more competition, more private finance so as to lessen public expenditure, less bureaucracy, more flexibility, greater opportunities for the

. . . The IMF, World Bank and World Health Organisation

In the 1990s, the Philippines instituted a cost cutting and privatisation programme in the health sector. Now half of hospital beds are private and most costs are paid for by patients. An insurance system covers just one-third of the population. The government now spends less than three per cent of its budget on public health, but nearly 30 per cent on servicing its debt.

Just three per cent of the World Bank's \$1.8 billion poverty alleviation programme in the Philippines goes to fund health care -and most of that goes towards projects related to women's reproduction. (The project's real intent is population management, comments Antonio Tujan, a Philippine NGO worker.) The World Bank pays more for the services and infrastructure for the Subic Bay freeport zone, the former US naval base which is being turned into a base for US corporations such as Oriental Petroleum, than on health.

Other World Bank and IMF policies have undermined people's ability to pay for health care: the lifting of price controls; the freezing of wages; the devaluation of local currencies; and the reduction of subsidies on basic essentials such as food and transport. Many people, especially women, now work longer hours for lower wages and have less food. Falling incomes, increased prices for essential commodities, declining basic services and an increased women's workload have all led to more illness and deaths.

All these "reforms" have helped commercial interests to cater to wealthier people in developing countries through private health care insurance and private hospitals. Most people are left dependent on a poorly-equipped, shrinking public sector; it is the affluent who call upon rapidly-expanding and increasingly high-cost private services.

"Before, everyone could get health care", said one person interviewed during the World Bank's 1999 poverty consultations, "but now everyone just prays to God that they don't get sick because everywhere they ask for money." Conclude medical researchers Kasturi Sen and Meri Koivusalo:

"Strong private and increasingly transnational interests are . . . altering the nature and even the existence of public health care . . . systems throughout the developing world with the helping hand of international agencies such as the World Bank."

The World Trade Organisation regards itself as the coordinator of the international transfer of such policies. It asks "How can WTO Members ensure that ongoing reforms in national health systems are mutually supportive and, whenever relevant, market-based?" The EU, similarly, states that one purpose of the WTO is:

"to provide a forum for negotiations on trade relations, with a view to achieving greater coherence in global economic policy making. In practice this will involve close co-ordination with the policies of the International Monetary Fund and the World Bank."

World Health Organisation

More recently, the World Health Organisation (WHO) has joined the privatisation trend through its advocacy of "public-private partnerships", a trend which is leading to the partial privatisation and commercialisation of the UN system itself. Cuts in national government contributions to WHO have been one of

the forces driving it into "partnership" with industry and the private sector. WHO's budget for the financial year 2000/2001 is US\$1.86 billion, while that of baby food producer Nestlé is US\$7.9 billion for its promotional activities alone. The WHO approach has been criticised for benefiting commercial interests rather than public health initiatives.

Efforts are also being made to restrict the WHO from regulating industry in areas with health implications such as baby food, pharmaceuticals, tobacco and alcohol. In 2000, WHO itself admitted that tobacco company consultants have had staff positions at WHO.

Sources: Hall, D., *Globalisation, Privatisation and Healthcare-A Preliminary Report*, Public Services International Research Unit, Greenwich, January 2001, website: www.psiu.org; Price, D., Pollock, A.M. and Shaoul, J., "How the World Trade Organisation is Shaping Domestic Policies in Health Care", *The Lancet*, 354, 27 November 1999, pp.1889-1892; "Health Hazard: How the System Makes Us Sick", *New Internationalist*, Issue 331, Jan/Feb 2001, website: www.newint.org; Sen, K. and Koivusalo, M., "Health Care Reforms and Developing Countries: A Critical Overview", *International Journal of Health Planning and Management*, Vol. 13, 1998, pp.199-215; Koivusalo, M. and Ollila, E., *Making a Healthy World: Agencies, Actors and Policies in International Health*, Zed Books, London, 1997; TRAC, *Tangled Up In Blue: Corporate Partnerships at the United Nations*, TRAC, 2000, website: www.corpwatch.org; Richter, J., *Holding Corporations Accountable: Corporate Conduct, International Codes and Citizen Action*, Zed Books, London and New Jersey, (forthcoming September 2001); HAI, *Public-Private Partnerships: Addressing Public Health Needs or Corporate Agendas?*, Health Action International, Amsterdam, May 2001, website: www.haiweb.org/campaign/PPI/seminar200011.html.

The damage to public services happens through commercialisation and privatisation rather than the entry of foreign capital.

The objective of GATS is to increase trade in services, not to improve health or social equity.

workforce, and more modern management practices. In practice, however, cartels develop and corruption is rife. Public money provides guarantees for private companies which simply avoid competition from the public sector. There is little or no accountability or regulation within the private sector, and job cuts or reduced conditions of work are common.

The bulwarks of public health – air quality, safe drinking water, food safety, road safety, drainage and sanitation – have been under threat because of privatisation for some time now; under GATS, they could be permanently dismantled. The consequences are apparent in many poorer countries today and in nineteenth century Europe: high mortality rates, especially high maternal death rates, a proliferation of contagious diseases, and high levels of poverty and homelessness.⁷¹

The WTO Secretariat has acknowledged that restricting domestic regulation creates a tension between trade expansion and national sovereignty. But another critical tension is that between the goals of trade more generally, as facilitated by privatisation, and the public interest. As David Hall points out:

“Whether the private companies involved are national or foreign is arguably a less important issue for public services than the impact of privatisation on financing or service provision . . . There may still be negative development consequences of globalisation of these services, from the entry of foreign capital, but the distinctive damage to public services happens through privatisation”.⁷²

Health care researchers Allyson Pollock and David Price stress that “the crucial factor is not so much domestic sovereignty as the way in which public interest and public-health objectives can be over-ridden by objectives that further trade”.⁷³ Health care researcher Meri Koivusalo argues that what the WTO really deals with “is not trade barriers between nations or interests between the North and the South, but . . . incentives and mechanisms which deal with the respective rights, responsibilities and capacities of the private and public sector.”⁷⁴

Turning Health Care Into Health Markets

Health care is just one example of a public service threatened by GATS. Commercial interests now provide some of the health services in many countries, sometimes in competition (albeit limited and regulated) with public providers.⁷⁵ In the UK, for instance, for-profit nursing homes and privately-financed hospital buildings provide health services in competition with public ones.⁷⁶

This dual system gives the WTO a useful rationale for encouraging further competition and privatisation through GATS:

“The hospital sector in many countries . . . is made up of government-owned and privately-owned entities which both operate on a commercial basis, charging the patient or his [sic] insurance for the treatment provided . . . It seems unrealistic in such cases to argue for continued application of Article 1.3 [that the service is a government service] and/or to maintain that no competitive relationship exists between the two groups of suppliers of services”.⁷⁷

The stakes are huge: expenditure on health in OECD countries is estimated at more than US\$3 trillion annually.⁷⁸

Marketing Health in Chile

At the beginning of the twentieth century, Chile was a pioneer of equal access to health services for all. By the end of that century, it had become a pioneer in free market policies in health care.

Between 1979 and 1985, the government sharply reduced government and employer contributions to health care services, passing more and more of the costs on to users through wage and salary withholdings and co-payments.

By 1995, seven per cent of the gross pay of every person formally employed was withheld for health care. The employee now decides where this deduction goes. Since 1981, one option has been into a "plan" or contract offered by an ISAPRE, (Instituto de Salud Previsional), a health insurance company modelled on those in the United States. Another is to the public sector's National Fund for Health, FONASA (Fundacion Nacional de Salud) and a third option is to the public health care facilities, the remnants of the national health service, the SNS (Sistema Nacional de Salud).

According to neo-liberal free market thinking, these changes were meant to foster the rise of for-profit providers of health services which have to compete with each other in the medical marketplace and are thus forced to provide better care and to keep costs down. While less is spent from the public purse for health services, reducing employers' expenditures on health benefits is supposed to enable more workers to be hired and Chilean industries to become more competitive in world markets.

But while a greater number of health care systems (both public and private) offering an array of options at various prices is now available to each person, they are not necessarily accessible to each person. The determining factor is not "choice" but one's ability to pay. This is clearly indicated by looking at who takes advantage of which "options". The health insurance companies, the ISAPREs, have captured most high-income Chileans while the public system has wound up with all the low-income workers.

Almost three-quarters of the ISAPREs' clients are in the top 30 per cent of Chileans by income, while 41 per cent of those in the public system are in the bottom 30 per cent. The average income of an ISAPRE client is about seven times that of the average wage earner in the public system. In 1989, 21 per cent of the users of the public system – over two million people – were too poor to have withholdings or make co-payments.

A beleaguered public health services system is meanwhile supposed to attend to the health needs of 70 per cent of Chileans, not to mention 100 per cent of the nation's public health costs (environmental health, sanitation control and occupational safety).

It has become grossly under-resourced: the government cut back sharply on its contribution to the public system on a per-person basis by 43 per cent between 1974 and 1989. Between 1973 and 1988, the number of employees in the public health system was slashed from 110,000 to 53,000, even though the number of people dependent upon it grew by one million during the same period. The remaining SNN employees have seen their real wages fall while they are assigned greater workloads in deteriorating working conditions.

Investment in equipment and facilities has also been drastically cut. A doctor at the Central Emergency Hospital admitted:

"We don't even have enough sheets. We have to tell patients' relatives to bring sheets, syringes, medicines. It's embarrassing and it's demoralizing to work now in a public hospital. The patients we see here and their families – they have to sell everything, their furniture, everything, to afford the medicines. Sometimes, it's better not to tell them that, yes, we could do something to cure you or your loved one because you know they won't be able, even with the help of relatives and friends, to come up with the money for the medicines."

The sharp curtailment in government funding for health care, together with the flight of higher-income people from the public system, have generated inefficiencies. A patient who has to stay in hospital for seven

days waiting for an X-ray takes up space and other resources.

Excessive waiting periods mean that many patients end up in emergency care, placing their lives in extra jeopardy and using up more resources. One hospital administrator said that an ulcer is not likely to be attended to until it bleeds when it will be treated as an emergency at a greater financial cost. Between 1984 and 1987, the greatest increase of all categories for medical treatments was in "emergencies", accounting for 40 per cent of the total.

The net impact of health care liberalisation has been to shift most of the cost of health services onto consumers. In 1989, over 81 per cent of all health expenditure in Chile came from the wallets of consumers themselves (up from 19 per cent in 1974). The government contributed only 17 per cent (down from over 61 per cent in 1974). Employers contribute only 1.6 per cent at most – by and large voluntarily at that; yet in 1974, their mandatory contributions had amounted to over 19 per cent of total health expenditure.

The shift does not fall evenly on all Chileans. Middle-class and poorer Chileans have seen dramatic increases in what they must pay for health insurance and services. Many higher-income Chileans are likely to be paying less; those 15 per cent of Chileans with higher incomes who use ISAPREs contribute not a peso to the public system. By the late 1980s, the government was paying for only 38 per cent of the public system's budget. It is the comparatively low wage earners in the public system – mostly hard-pressed lower middle-class Chileans – who subsidise heavily the health care of over two million poorer Chileans. In the words of Dr Raul Donckaster of the Medical Association, "It's the poor who help the poorest".

Source: Collins, J. and Lear, J., *Chile's Free Market Miracle: A Second Look*, Food First Books, Oakland, California, 1995.

To date, however, GATS has not been instrumental in privatising health care services and opening them up to foreign competition.⁷⁹ Health and social services are “trailing behind other sectors” in the rate they are being listed under GATS as open to competition. The WTO acknowledges that some governments do not want to commercialise their hospitals because they are part of their “national heritage”.⁸⁰

As of 1998, 59 countries had put one or more aspects of their professional (medical, dental, veterinary, nursing, midwifery, physiotherapy) services or health-related and social services (including hospitals) under GATS. Medical and dental services had the highest tally with 49 countries while 39 countries had agreed to open up hospital services to foreign suppliers. In the financial services sector, including health insurance, however, 76 countries have made commitments.⁸¹ Poorer countries have made more commitments in the hope of attracting services they lack. Sierra Leone is the only country to have included all eight health service categories under GATS, while the US has included just hospital and health insurance services.

Even if they have made such commitments, however, such countries can still limit foreign suppliers’ market access and specify which ways of supplying the service are open to competition (*see* Box, p.6). The highest number of restrictions in ways of supplying health services is in “commercial presence”.

Health Care for the Few

In Chile, the ISAPREs (Instituto de Salud Previsional), health insurance companies modelled on those in the US, illustrate what happens when the private sector is given free rein in providing health care within the free market model.

- **The essence of an ISAPRE’s profitability is discrimination.**

Most of the 30 or so ISAPREs do not themselves operate health service facilities: they sell health insurance, and by the profit-seeking logic of the marketplace, they sell insurance only to those least likely to need it. Most ISAPREs screen out people with certain congenital diseases and pre-existing cancer and those thought to be at high risk of contracting AIDS. They refuse applicants over 60 or 65 years of age or charge them very high premiums; by 1990, only two per cent of ISAPRE subscribers were retired. Psychiatric and dental care are rarely covered. The ultimate safeguard for the ISAPREs is that the annual premium for customers who have used health care services over the course of a single year is substantially hiked or the customers are dumped with little prospect of buying coverage from another ISAPRE. ISAPREs initially rejected women of child-

bearing age or required women to certify that they were not pregnant when they took out insurance.

- **Government interventions consistently favoured ISAPREs to the detriment of the public health system and the public purse.**

When ISAPREs were authorised legally in 1981, they took off slowly. The government then intervened to expand their market. In 1983, it increased mandatory health care withholdings from four per cent of wages and salaries to five per cent, and then to six per cent in 1984 and to seven per cent in 1986. The 1986 Health Law mandated the public system (FONASA) to take on the payment of all medical and maternity leaves and of neo-natal care for those insured under ISAPREs. It was also decreed that FONASA reimburse wages lost by ISAPRE subscribers due to illness after the tenth day of absence from work and during the 90 days of maternity leave. Since ISAPRE members tend to be higher earners, it is more expensive to cover their leaves of absence than those of people who are not with an ISAPRE. Yet again, the majority of Chileans, lower middle class and lower income, wind up subsidising the higher-income minority.

- **ISAPREs are allowed to use public facilities for emergency cases and**

major procedures such as heart and brain operations, thereby avoiding costly investments in such facilities.

- **Private medical care insurers, by their very nature, do not invest in preventive health care.**

• **Advertising and sales expenditure have become a major part of the “costs” of privatised medical care.** In 1989, one-sixth of ISAPREs’ expenditure went on advertising, sales and related administrative expenses. Many ISAPREs spent more than that, some over one-third.

• **It is meaningless to argue that ISAPREs give “more efficient” or even “better” health care than the public system since they have so many more resources.** In 1989, the ISAPREs had 6.5 times more financial resources per person than the public system. ISAPRE clients consume 70 per cent of the total deductions for health care, even though they are less than 15 per cent of the national population. With the public system run into the ground, most Chileans today would choose to be in the private system if they could afford to do so.

Source: Collins, J. and Lear, J., *Chile’s Free Market Miracle: A Second Look*, Food First Books, Oakland, California, 1995.

During GATS 2000 talks, US negotiators have made health care a special target:

“The United States is of the view that commercial opportunities exist along the entire spectrum of health and social care facilities, including hospitals, outpatient facilities, clinics, nursing homes, assisted living arrangements, and services provided in the home”.⁸²

The US Coalition of Service Industries is calling for majority foreign ownership of all public health facilities to be allowed:

“We believe we can make much progress in the [GATS] negotiations to allow the opportunity for US businesses to expand into foreign health care markets . . . Historically, health care services in many foreign countries have largely been the responsibility of the public sector. This public ownership of health care has made it difficult for US private-sector health care providers to market in foreign countries.”⁸³

The US private health care sector also wants to gain access to “rapidly expanding health care expenditures in many developed countries” experiencing “an increase in their aged population”.⁸⁴

Using GATS to Privatised Public Health Care

GATS could facilitate further privatisation and competition in health care services if more countries are pressured during GATS 2000 negotiations to list health care services on their schedules of commitments in all ways of supplying the service.

In the longer term, challenges under GATS to public services could be another way. The US could take Britain to the WTO disputes panel, for instance, if the British government or any other body refused a US multinational permission to buy a British public National Health Service hospital which had been financed through the Private Finance Initiative. Similarly, the Canadian province of Alberta plans to allow private, for-profit hospitals to provide services previously provided only by public hospitals. If any of these private entities are based outside Canada (and a US-based company could use NAFTA to gain access), Alberta would be obliged to extend the same rights to every other “like” foreign provider under the GATS most-favoured nation rule.⁸⁵

A third way GATS could facilitate privatisation and competition is if mechanisms and principles underpinning the design, funding and delivery of public services are in effect proscribed – for example, if the vague requirement for “domestic regulation” to be “least burdensome” to trade is defined as “pro-competitive” (see Box, p.8).⁸⁶ “Universal risk pooling”, for instance, is a key principle of public health care services and would be at risk because it is not “pro-competitive”. It means that the different risks that people will need health care services are pooled together across society. Some people are healthy most of the time and need little health care, while others are chronically ill for years on end and need more. Access and entitlement to health care services are based on an individual’s need for them, not on their ability to pay.

Also threatened is another widely-used principle: “cross-subsidisation”. Under this principle, areas or services which cost less subsidise areas and services which cost more. In many countries, profitable services such as international telephone calls have subsidised

Private health providers do not aim to provide health care to society, but health products and procedures to individuals.

The United States has the most expensive health system in the world covering the lowest percentage of its population.

Privatised health services which can be bought and sold internationally will lead to less effective, more costly and more inequitable health care.

The WTO is contemplating the systematic destruction of publicly-owned, funded and accountable services.

less profitable but socially beneficial telephone services in rural areas. In transport, bus services or railway branch lines serving outlying areas are easily paid for by routes in busy, more congested areas.⁸⁷ Risk pooling and cross subsidies between rich and poor, healthy and sick ensure that all get tolerably equal access to similar levels of care because the basis of public services aims to be redistribution.

Getting rid of cross-subsidisation is an essential step in service privatisation. It allows corporations to divide up integrated health care services, extract the more profitable ones and the more profitable patients (usually those who least need health care) and leave behind a reduced public sector. Such break-ups threaten the principles of universal coverage and shared risk that tax-funded (as in Britain and Canada) or social-insurance-funded (as in France or Germany) health care systems generally uphold.⁸⁸

The trend is toward something like the United States' health care system, which has become dominated by for-profit organisations over the past decade. There, researcher Robert Kuttner observes, tacit cross-subsidies are being eliminated and hospitals treated more and more as businesses:

“Temporary losses are defensible only as investments in future profits, so cross-subsidy must be avoided . . . There is no place for uncompensated care, unprofitable admissions, research, education, or public health activities – all chronic money losers from a strictly business viewpoint”.⁸⁹

A revised GATS could not only reduce equitable access to health care services. It could also undermine mechanisms for containing the costs of public sector health care. It could override national regulations governing health care and affect the kind of services provided, restricting rather than enlarging people's choice of services and of the places in which they are provided.⁹⁰ With reduced public expenditure on health and social services, women will increasingly have to take up the slack and nurse the sick who cannot find or afford health care.⁹¹

Public versus Private

The main argument put forward for private health care is that it improves the quality of care. If patients have to pay for services and can choose where they spend their money (or the public money they are doled out), then health and social services will be compelled to become more economically responsible and efficient because they have to respond to competition.

But it is difficult for patients to assess the quality of the health and social services provided by private companies in any meaningful way. Despite “performance” data such as league tables ranking hospitals according to death rates or operations performed, most people will not be equipped to decide where they should be treated, by whom and with what, without the advice of their doctor. Moreover, rules and regulations governing the public sector, for instance, setting minimum care standards, often do not apply to or are not enforced in the private sector.

In the UK, cost has become the only relevant factor. But “the relentless drive towards ever greater cost savings through contracting out has, in many cases, had a disastrous effect on service quality”.⁹² Hospital trusts which have contracted out “hundreds of millions of pounds of support services over the past 17 years admitted that cost-cutting had

continued on page 25 . . .

July 2001

The CornerHouse

Briefing 23: Trade and Health Care

Britain's National Health Service

Privatisation by the Back Door

The UK's National Health Service (NHS) has been a beacon to the world. Despite being under-funded and over-worked, particularly over the past two decades, it still provides high-quality health care to most of the people in Britain more cheaply and more efficiently than almost any other medical system in the world, according to the OECD.

The health service is paid for out of general taxation, which is considered, even by the *Financial Times*, to be the fairest, most economical, most efficient and least bureaucratic way of funding the great bulk of health care.

But under the guise of modernisation and reform – which many of those working within the NHS believe is necessary – the country's health and social services are being commercialised and privatised.

Given the general popularity of the NHS and its entrenched public nature, however, this process has been ad hoc, fragmented and covert. A first step has been to undermine confidence in public provision through unrelenting criticism of public services.

Some of the methods to encourage for-profit involvement in the NHS are well-known: compulsory competitive tendering for "support" services such as cleaning, catering, laundry, computing and laboratory analysis, for instance. But other, more subtle mechanisms, are less familiar, mechanisms which the World Bank is recommending to other countries:

- separating the purchaser from the provider of health services;
- introducing commercial accounting and private financing;
- allocating resources on the basis of each patient's health risks rather than a population's health needs;
- introducing user charges and private insurance.

Purchaser-Provider Split

In 1991, the Conservative government introduced an internal market to the NHS by separating the providers and purchasers of health care services from each other. Whereas health authorities throughout the country used themselves to plan and provide hospital services to a local population within a geographic area on the basis of its anticipated health needs, now they had to purchase care from NHS trusts (or the private sector) providing these services.

The NHS trusts running the hospitals, meanwhile, had to compete with each other to obtain patients. Services were separated from each other and other activities, packaged into saleable and marketable items, priced separately and offered to purchasers, who began to shop around for the best financial deals. Despite further organisational changes in 1999, the purchaser-provider split remains.

Commercial Accounting

At the same time, commercial resource accounting procedures were introduced. Since 1991, NHS trusts have had to pay a "capital charge" to the government for the use of buildings and equipment – even though the state already owns them outright. The cost of replacing these assets as new is estimated; the trusts then pay 6 per cent of this valuation out of their annual income (even though if the state were to replace the assets, it could borrow money for about 3 per cent).

Trusts also became legally bound to break even, ensuring that their expenditure matched or was less than their income. Indeed, the only legal requirements of NHS trusts providing hospital and community services are now financial and are not related to health care at all.

There are no legal mechanisms to ensure that they serve the interests of the local communities from which they draw their patients.

In 1996-7, one-third of NHS trusts failed to meet at least one of their financial targets. Many continue to fall short. Current proposals would enable private firms or other trusts to take over trusts which do not meet their statutory financial targets.

In an attempt to balance their books and pay the capital charge, trusts have had to reduce their expenditure or increase their income. Many have made major cuts in staff and in the services they provide, such as long-term care, rehabilitation and elective surgery (surgery for non-life-threatening conditions). Unsurprisingly, waiting lists for operations have grown. Trusts have also reduced their capital charge by selling off assets: the higher the value of the asset base, the higher the capital charge and the lower the budget available for clinical care.

Trusts have also tried to generate extra income by getting in more private patients or more funds for commercial research, or by treating more patients more quickly. "In effect, the hospital becomes a factory for conveyor belt care", says health policy professor Allyson Pollock and her colleagues.

Thus hospitals and services are now planned more according to the financial demands of trusts than to the clinical needs of the people in the area they serve. Affordability has become far more of a critical constraint in planning priorities in which clinicians and public health doctors are not required to be involved. Administrative running costs within the NHS are estimated to have doubled because of the imposed market processes, rising from 5 per cent to 12 per cent of total costs.

Moreover, the introduction of

the capital charge provided a stream of funding that could be used to pay for new capital investments – one that could be channelled directly towards the for-profit sector.

The Privatisation of Public Funding

Capital spending within the NHS, allocated by the government to maintain, refurbish or replace buildings, has been insufficient for years. The backlog of maintenance and repair in the NHS is now over £3.1 billion.

But public capital funding has now been virtually eliminated. Trusts, which became responsible for capital financing (by the introduction of the capital charge) instead of the government, have thus had to turn to the private sector to finance new investments if they want to remain “competitive” in attracting purchasers of their services (even though private finance is more expensive than public financing).

The Private Finance Initiative (PFI), launched in 1992 by the Conservative government, was extended to the National Health Service in 1997 by the Labour government. A source of finance, not funding, PFI allows private companies and consortia to build and own hospitals which they lease to the NHS for between 20 and 60 years. The NHS pays for the building’s capital and running costs out of its incoming (mainly public) revenue. In effect, public funds subsidise the expansion of the private sector.

PFI hospitals cost the NHS more than if it were to build its own hospitals. A new hospital in Edinburgh, for example, would have cost the state £180 million, but will cost it £30 million a year for 30 years at current prices – £900 million in total. The health authorities will meet these costs by selling three existing hospitals, and cutting 33 per cent of its beds and 20 per cent of its staff budgets.

Most PFI schemes involve centralising hospitals on a single, usually cheaper, site and selling the land on which previous hospitals were built. Private

money is now funding the largest hospital rebuilding programme in Britain for 30 years. And, ironically, as Allyson Pollock points out, it “is being paid for by the largest service closure programme in the history of the NHS”.

Overall, the introduction of the private finance initiative to hospitals in the National Health Service has resulted in a 30 per cent reduction in staffed acute beds and a 20 per cent reduction in clinical budgets and workforce. Some 12,000 NHS beds have closed since 1997. Government consultants have calculated that every £200 million spent through the PFI leads to the loss of 1,000 doctors and nurses. The costs of proposed developments have soared 75 per cent.

Even in the short term, payments for a PFI hospital are usually higher than the capital charge to the government. Annual payments range from 11-18 per cent of the construction costs, compared to the 6 per cent capital charge. Additional payments cover cleaning, lighting and laundry services that the private hospital provides. Shareholders in PFI schemes can expect annual returns of 15-25 per cent. As hospital trusts would never be allowed to go bankrupt, there is no risk to the consortia’s funds.

The planning, supply and support of PFI hospital services is left to private sector consortia. Detailed information about PFI hospital schemes, particularly planning assumptions about the numbers of beds and services needed, is rarely publicly available because of commercial confidentiality. The data that has been obtained, however, suggests that projections about clinical activity and beds are lower than current trends and health authorities’ projections.

Although ostensibly financing the infrastructure only, the private sector decides how to supply the services and the investment needed to support these services. Health authorities and trusts no longer control the number of hospital beds or the levels of service they believe are required for the people in their area. The government health minister said in November 2000:

“We had to get the hospital building programme started. If you like . . . we had to create a market in PFI because there was not a market.”

Although PFI is an expensive way to build new hospitals and leaves less money to be spent on patient care, the government recently extended the initiative to some 3,000 local doctors’ premises, community pharmacies, health centres and long-term care facilities. Already health care companies and property developers are expanding into the ownership and provision of primary care premises. The government is also considering encouraging the private sector to coordinate payroll, administration and computer services for local doctors, and even the provision of clinical services under PFI arrangements.

In the year 2000, the UK government promised £20 billion (\$31 billion) of extra money to the national health service over four years. But where will this taxpayers’ money end up? A large chunk of the billions the government has promised to the National Health Service could simply disappear into the for-profit sector.

Per-Patient Funding

Health authorities receive block budgets from central government on the basis of the anticipated needs of all the people in the geographical area they serve. But the new NHS primary care trusts which came into effect in April 2001 will be reimbursed not on the basis of geographic populations but on that of general practitioner’s patient lists. This fundamental shift in funding allocation is similar to the US insurance based system (see pp.25-26). It gives local health care practices incentives to select carefully the patients they enroll (“cream skimming”) and to argue for reimbursement linked to individuals’ needs. Both undermine the risk pooling and risk sharing basis of resource allocation on a geographic basis.

Moreover, the government recently introduced legislation which allows trusts to put a time limit on the care they provide to a patient (rather than providing it for as long as a patient needs it). The legislation also creates an incentive for them to redefine some care as “personal” care (which can be charged for) rather than “nursing” care. Taken together, these changes pave the way for replacing public sources of

funding with private in some areas of care. Trusts will be under financial pressure to encourage patients to take out private, voluntary insurance.

Overall, the reimbursement mechanisms are being altered in ways that facilitate a shift towards personal insurance and user charges for care that used to be free at the point of delivery.

Private Insurance

Despite the running down of the NHS, private medical insurance in the UK has barely grown in a decade, certainly not to a level that it would erode the social solidarity needed to support a state-run, taxation-based medical service. Just 11 per cent of the UK population, 6.5 million people, have private insurance, largely through their employer – and they are concentrated in the richest quarter of the population.

Many people in Britain still think of private medicine as “hernia fixes in nice surroundings” and assume that if you are seriously sick, you need to be in an NHS hospital. An advertisement for one private health care insurance scheme plays on just these assumptions: “We use the private facilities of the NHS [teaching hospitals] in London, so you get the best of both worlds. First class medical treatment when you need it.”

Those who want to leapfrog NHS waiting lists tend to ignore the insurance market and simply use their own “out-of-pocket” money for private treatment. The proportion of elective treatments (for non-life-threatening conditions) paid for privately is just over 13 per cent and has changed little since 1981.

Moreover, most private medical insurance does not cover emergency treatment. It tends to cover unforeseen (acute) medical conditions, but only if treatment is likely to lead to a full recovery. It does not usually pay to treat long-term or “chronic” conditions that have no known cure, such as arthritis or asthma, or that lead to permanent disability. Private medical insurance focuses on those who are good medical risks and rarely extends to the over-75s who are most in need. Where it does, the cost of premiums escalates dramatically to reflect the presumed higher risk.

If those who could afford to do so opted out of the public health service, for instance, by claiming rebates for taking out private health insurance, the NHS would still retain the vast bulk of its business – children, the elderly and chronic sick – but it would lose large parts of its income.

Looking further into the future, health care financing could have implications for the genetic testing of individuals for their predisposition in later life to certain illnesses. There is concern that people could be charged higher health or life insurance premiums, or refused insurance altogether, if they had to tell the prospective insurer the results of any genetic test they have had, particularly results indicating a susceptibility to a disease. The British government recently stated that more genetic tests would soon be available on the NHS, but that they would not have these discriminatory effects because the health service is publicly funded from taxation, not from insurance. But the market changes introduced into the health service over the past decade which pave the way for private health care insurance cast doubt on these assurances. As NGO activist Pat Mooney points out, “if your doctor is also your insurance agent, the fight for genetic privacy is going to seem a little silly.”

Private Hospitals to the Rescue?

Britain’s 300 or so private hospitals predominantly treat five ailments: replacement hips, hernias, hysterectomies, heart conditions and haemorrhoids. At present, they do little work at either end of the medical spectrum where most patients use or need the health system: primary care such as visits to the local general practitioner which account for nine of ten patients using the NHS (a market the private sector is trying to enter), and catastrophic injuries and illnesses. The NHS did buy in 30,000 operations from the private sector in 1999, but carried out 6.5 million itself. In the year 2000, the private sector carried out some 800,000 elective surgical procedures.

But private hospitals could, if permitted, corner the market in conditions such as hip replacements,

cataracts and heart bypass grafts, and then drive prices up. More public services could be contracted out and more charges introduced. As *The Observer* points out:

“what the Government – and therefore all taxpayers – can achieve with its health budget will diminish because private providers, which have to make profits, will be dearer”.

The need for commercial returns, particularly for companies with shareholders, could increase the cost of providing health care.

When the US government sent patients to private hospitals run by the Hospital Corporation of America (HCA), the company sent back inflated bills and expenses. The case has now become the largest fraud investigation in US history. The UK Department of Health has no experience of preventing private hospitals finding imaginary illnesses or performing unnecessary operations.

Costs, moreover, still fall on the public sector for the training of nurses and doctors and for emergencies when operations go wrong – private hospitals tend not to have emergency backup. *Observer* journalist Nick Cohen points out that the NHS does not “appear to know that their [private sector] record of treating patients who suddenly develop complications and need emergency care is terrible”. In the year 2000, there were nearly 142,000 admissions from private hospitals to the NHS.

But instead of restoring public provision of beds or abandoning private finance, the government has turned to the private sector to make up the shortfall which it itself produced. In October 2000, it signed a “concordat” with private hospitals and nursing homes to treat NHS patients for waiting list operations, intensive care, and rehabilitation and preventive services for the elderly (intermediate care). The arrangement will make it easier for private sector companies to operate former NHS facilities and clinical services and to take over the clinical workforce. The government is also considering allowing private contractors to

manage health authorities and primary care groups, and to run specialist services such as diagnostic centres, cardiac and neuro surgery, and radiotherapy.

Just half the private hospital sector's 10,000 beds are usually occupied compared to the 186,000 in the public sector which are now almost always occupied. Two-fifths of general and acute hospital beds are occupied by people, mainly elderly, who are not well enough to go home but not ill enough to need to stay in hospital. New legislation passed in 2001 allows NHS bodies in future to redefine what health care shall be free and to charge patients for "personal" care (washing, feeding, toileting and dressing) but not "nursing" or "medical" care. There are no regulation or accountability mechanisms for this increasing use of the private sector.

These proposals could enable the private sector to expand rapidly as hard-pressed hospital trusts shift elderly patients from hospital beds into for-profit intermediate care. The trusts would pay for the first six weeks of their stay, but subsequently charge for personal care, which it would be in the trusts' financial interests to define as broadly as possible. Ultimately, public funding could be further reduced or withdrawn altogether. This was the pattern followed by long-term nursing and residential care in the 1980s.

Privatisation of Long-term Nursing and Residential Care

In 1983, the government allowed people entering private homes to claim social security (welfare) to pay for their care, an option not available to residents in public homes provided by local authorities or the NHS. This system created an incentive for public authorities to switch the elderly, disabled and mentally-ill into the private sector, close down the services and homes they did provide, and thereby release funds for themselves through reduced expenditure and the sale of assets.

This "unrestricted availability of an untapped funding stream", says consultant geriatrician Peter Chome, fuelled the extraordinary growth in private institutional care in the 1980s and 1990s: 175,000 places in 1985 had nearly quadrupled by 1998 to 650,000 places, a growth funded almost entirely out of the public purse. Today, the state provides not even one-fifth of places but pays for the care for 70 per cent of people in private residential and nursing homes. Residential and nursing home care firms make much of their profit by paying low wages to casual labour, mainly women. Low staffing levels are associated with poor quality of care, but there are no legal minimum staffing requirements.

Once the private sector had developed, the government switched the funding for long-term care from the national social security budget to that of local authorities, which could set eligibility criteria. An increasing number of some of the most vulnerable groups in society – the elderly, disabled and the long-term sick – now pay for their own care, or go without. There are widespread differences across the country in assessing needs and determining eligibility for services or for financial support, creating inequities. Access to care is increasingly based on ability to pay. Long-term care has become primarily an individual rather than collective responsibility. Concludes health care researcher Allyson Pollock:

"there is little evidence to show that the shift to private-sector financing and ownership of long-term care by these companies will save money, especially if the corporations in the UK have similar patterns of spending on administration, capital and profits to those in the USA."

Conclusion

Since it was set up in 1948, the NHS has made great gains in ironing out inequities throughout Britain in the availability and accessibility of health and social care services. The various structural changes made to the financing and delivery of these services over the past decade, however, could reverse these efforts, conflicting as they do with the principles of universal coverage, shared risk and redistribution that tax-funded or social insurance-

funded systems generally uphold and aim for.

The NHS would not be dismantled but reconfigured. It could be left as a "sink service" trying to cope with emergencies and complex health conditions, while the private sector made its profits from the more lucrative parts of health care such as elective operations and intermediate care – and from public subsidies

Once the NHS model of universal care, free at the point of delivery, is lost, it will be difficult, if not impossible, to get it back. A publicly-accountable health system, resourced with adequate public funds, is the most effective way of providing decent health care to the majority of a country's citizens.

Thanks to Allyson Pollock.

Sources: Gaffney, D and Pollock, A., *Putting a Price on the PFI*, UNISON, 1998; Eversley, J. and Sheppard, C., *Thinking the Unthinkable: The Case Against Charges in Primary Health Care*, *HealthMatters*, 2000; Cohen, N. "Perils of Going Private", *The Observer*, 13 August 2000, p.27; Pollock, A., Price, D. and Dunnigan, M., *Deficits Before Patients*, University College London, 2000, website: www.ucl.ac.uk/spp; "Do Old People Have a Future? And Is Any of it in the NHS?" *Health Matters*, Issue 40, Spring 2000, website: www.healthmatters.org.uk; *New Life for Health by the Commission on the NHS*, Vintage Press, London, 2000; Pollock, A., "PFI-You'll Pay For It later", *Health Matters*, Issue 38, Autumn 1999, pp.10-11, website: www.healthmatters.org.uk; Gaffney, D., Pollock, A.M., Price, D. and Shaoul, J., "The Private Finance Initiative" (four articles), *British Medical Journal*, 3, 10, 17 and 24 July 1999; Macfarlane, A. and Pollock, A., "Statistics and the Privatisation of the National Health Service and Social Services" in Dorling, D. and Simpson, S. (eds.), *Statistics in Society*, Arnold, London, 1998, pp.252-262; Pollock, A.M., Player, S. and Godden, S., "How Private Finance is Moving Primary Care into Corporate Ownership", *British Medical Journal*, Vol 322, 21 April 2001, pp.960-963; Pollock, A.M., "Will Primary Care Trusts Lead to US-style Health Care?", *British Medical Journal*, Vol 322, 21 April 2001, pp.964-967; Harrington, C. and Pollock, A.M., "Decentralisation and Privatisation of Long-term Care in UK and USA", *The Lancet*, Vol 351, 13 June 1998, pp.1805-1808; Player, S. and Pollock, A.M., "Long-term Care: From Public Responsibility to Private Good", *Critical Social Policy*, Vol 21 (2), pp.231-255; ; Mooney, P.R., "The ETC Century", *development dialogue*, March 2001.

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directly led to the filthy NHS wards, dirty bed linen and inedible hospital food of public infamy”.⁹³ In the past three years, private companies contracted to provide support services to the NHS have incurred more than £2 million in penalties because they did not meet performance standards. Low pay and poor working conditions are two of the main causes of poor quality care, yet the benchmark of tendering and awarding contracts is cost rather than quality. Many NHS managers now recognise that “privatisation is not an infallible cure for service inefficiencies”.⁹⁴

Pressure from the families of hundreds of those who have died or been left disabled, brain-damaged or in severe pain as a result of inadequate care in private facilities led to a Care Standards Act in 2000 to enforce standards in private hospitals, and residential and nursing homes in the UK.⁹⁵ “Almost without exception, all of the tragedies . . . have been due to private hospitals being inadequately staffed”.⁹⁶

Analysis of the quality of care provided by for-profit entities in the United States casts further doubts on the assertion that the private sector provides better quality.⁹⁷ Says Peter Julian of the Council of Canadians, “Virtually every credible study ever done has shown that private, for-profit health care is more expensive, less efficient and of lower quality than public health care”.⁹⁸

But if quality of private (and public) care could be assured, evaluated by public health concerns rather than economic benchmarks such as the number of patients being treated or the length of waiting times,⁹⁹ it may be argued that using state money to pay a commercial company to provide health care services is no different from using it to fund public services. Moreover, private services, it is said, can fill the gaps in the public system.

In practice, the move to for-profit providers undermines the public sector in several ways (even though this private sector depends upon the public sector). When public and voluntary hospitals and health services have to compete with commercial providers for funding, whether provided by the state in the form of per-person public funds or private insurance or co-payments (additional payments by patients), less money ends up flowing into the public system. Competition also leads to competition for patients – the private sector tends to take the healthier and wealthier. Typically, the public sector is left to care for more vulnerable people whilst at the same time contending with cutbacks in funding.

The inevitable result is a loss of preventative services: the public sector has less money for these services, while the private sector is not interested in them. Private health providers do not aim to provide health care to society, but health products or surgical procedures to individuals. They will not supply inherently unprofitable care to anyone, least of all to those who are in no position to pay for it.¹⁰⁰ And as public service activist Dexter Whitfield points out, “the penultimate privatisation system is one in which taxpayers fund service provision, but the private sector own and manage the infrastructure and operate services”, the system that Britain is embarking upon.¹⁰¹ Health care, moreover, cannot be planned on the basis of individuals or highly-segmented medical practice: it is about populations and matching resources to known priorities.

Changes in health care provision in the United States and Latin America over the past two decades illustrate these trends clearly. In the early 1990s in the US, a growing number of hospitals, health maintenance organisations (HMOs, or insurer-type intermediaries between

Private insurers tend to select the “best risks”, mainly young and healthy people and reject those with chronic illnesses.

Many UK National Health Service managers now recognise that privatisation is not an infallible cure for service inefficiencies.

Health care is public rather than private or individual and should be funded, managed and governed as such.

employers and hospitals), nursing homes, home care services and hospices became for-profit companies publicly traded on stock exchanges. HMOs, transformed from a social form of medicine into multibillion-dollar businesses depending on a mixture of public funding, private health insurance and user charges, acquired non-profit hospitals cheaply and gained effective control over US hospitals. The pursuit of market share, the search for profitable admissions and relentless cost-cutting came to dominate all aspects of health care, even that provided by socially-oriented entities. By the late 1990s, pressure to protect profit margins had led to insurers and hospitals avoiding sick patients, the micro-management of physicians, a worsening of staff-to-patient ratios, and the outright denial of care to many. Instead of exercising greater efficiency in the use of available resources and greater integration of preventive and treatment services, the industry merely tries to avoid

Trade Encroaching on Health

The World Trade Organisation, not the World Health Organisation, is, according to some, the international agency with the greatest impact on health. Trade policies have a substantial influence on health and the environment, while measures to protect the environment and human health are often regarded as trade barriers. WTO agreements do allow regulations to be exempt from their rules because of public health concerns, but the exemptions have been narrowly formulated and interpreted on the grounds that countries could use health and safety regulations as covert trade barriers.

The dispute settlement process compares like commodities with like, ignoring to a large extent the processes and practices involved in producing them. It requires any regulations stricter than international standards to be based on scientific risk assessment. The implications for health, safety and environmental concerns are serious. For instance, no account is taken of the differences between a small-scale manufacturer and a multinational company, nor between production processes based on high labour standards and those based on low standards. There is no requirement for the trade experts who comprise tribunals to concern themselves with public health. Public health and safety measures which are the "least trade restrictive" are favoured. Voluntary measures are favoured over compulsory ones – labelling or fines over taxation, bans or advertising restrictions.

Individual responsibility is favoured over public responsibility.

Other WTO Agreements

Three other WTO agreements besides GATS have particular implications for health:

- **The Trade Related Intellectual Property Rights Agreement (TRIPs)** sets minimum standards of protection for all forms of intellectual property: patents, copyrights, trademarks, and industrial designs and licences. It obliges governments not to disclose information of commercial value provided for marketing licences, for instance, for pharmaceuticals and agricultural products. TRIPs allows patents to be granted on products and processes for 20 years. It allows patents on seeds, pharmaceutical drugs, genes and diagnostic tests, and also on minor innovations which are more "discoveries" than "inventions".

TRIPs does not promote free trade: it protects monopoly rights rather than encourages competition. Even free trade advocate Jagdish Bhagwati has described the WTO's intellectual property protection as "a simple tax" for most poor countries on their use of such knowledge, "constituting therefore an unrequited transfer to the rich, producing countries".

But TRIPs is justified on the grounds that it ensures investment in research and development (R&D), and balances the interests of rights-holders with those of consumers and the public. In practice, however, it has probably hampered R&D in areas

of little commercial interest, while the "balance" is tilted in favour of the rights-holders, not least transnational corporations.

TRIPs has recently gained international public attention because of its implications for the access people in the South have to pharmaceutical drugs, particularly AIDS drugs in Africa. But this is just the tip of the iceberg of TRIPs-related health concerns.

Patents increase the prices of pharmaceutical drugs which are paid for in most countries by the sick or from health budgets, whether public or insurance based. Patents do not direct corporate R&D towards serious or prevalent diseases or towards more cost-efficient drugs. Thus research on products which have large potential markets – obesity, ageing, impotence and baldness – prevails over health policy interests. R&D costs are rarely revealed, although it is known that a pharmaceutical company's marketing budget usually exceeds its R&D costs. Public institutions and public funding often carry out and support much of the basic research and product development needed before pharmaceutical drugs are brought to market, but this input is rarely recognised in the awarding of patents. The use and promotion of TRIPs thus encourages the misallocation of public funds to corporate marketing efforts, shifting money from the sick and the poor to corporate shareholders.

Moreover, intellectual property rights are hindering the dissemination of knowledge and technology. Industrial countries currently hold 97 per cent of all patents worldwide,

costs.¹⁰² “More than any other country”, concludes *The Economist*, “America has turned health care into a business”. Health care is the largest sector of the US economy; over \$1 trillion is spent on it every year, 46 per cent coming from government insurance programmes.¹⁰³ Nonetheless, some 44 million US Americans – one in six people – do not have health insurance, while millions of others are underinsured.¹⁰⁴

Latin America, meanwhile, (particularly Chile, Colombia, Peru, Argentina, Brazil, Mexico and Venezuela) has become a testing ground for the privatisation of health care in the name of “reform”, pushed by the World Bank, Inter-American Development Bank and US-trained national economists, and by the export targets of US health care providers and insurers. Private insurers tend to select the “best risks”, mainly young and healthy people. They reject those with chronic illnesses and leave behind those who cannot afford the insurance. Private companies

**“Health care is
not a commodity
and thus not a
tradable good”.**

International Labour
Organisation

while 80 per cent of patents granted in developing countries belong to residents of industrial countries.

● **The Agreement on Applications of Sanitary and Phytosanitary Measures (SPS)** covers food safety and regulations governing human, animal and plant health. Any measure a government takes to protect human, animal or plant life or health should be based on international standards, guidelines and recommendations drawn up by recognised bodies such as the FAO/WHO Codex Alimentarius Commission which deals with foods, hormones and additives. Any country wishing to implement stricter standards has to base them on scientific risk assessment.

The interpretation of this risk assessment, and thus the possibility of stricter standards, has implications for health policies. Disputes involving the SPS Agreement have raised issues about the burden of proof, the use of precaution, and definitions of risk assessment, scientific evidence and necessity.

Take, for example, regulations covering potentially hazardous methods of production, such as those which have potential carcinogenic or hormonal impacts if people are exposed to them over the long-term or at low-level doses. Such regulations are more open to challenges under the WTO than regulations governing finished products because of known evidence of the immediate and specific hazards caused by such products.

The WTO disputes panel has generally ruled that public policy measures not supported by sufficient quantitative scientific evidence violate WTO rules. For example, the

WTO ruled that the EU’s ban on hormone-treated beef was higher than international standards, was not supported by scientific evidence and did not address defined risks. Precautionary measures, however, may be appropriate for risks which are small but which have potentially catastrophic consequences.

The Codex Commission has long been dominated by representatives of the industries for which the Commission sets standards (although the industry representatives attend as part of a WTO member country’s delegation). The US has recently called for sections of Codex invoking the precautionary principle to be removed entirely.

● **The Agreement on Technical Barriers to Trade (TBT)** encourages countries to use internationally-agreed standards for their technical regulations but the regulations cannot be more “trade restrictive” than necessary. It does not identify the standards it favours – those of the WHO or of a manufacturer could be considered equally valid.

The International Standards Organisation (ISO), for example, is an industry-based organisation (not an inter-governmental one like Codex) which has been accepted by the TBT as eligible to draw up international standards. The ISO has recently become involved in setting water standards, raising concerns that such standards will be ratcheted downwards to reflect industry preferences and priorities rather than public health.

TBT thus has implications for the production, labelling, packaging and quality standards of pharmaceuticals, biological products and foodstuffs.

Poverty and Hunger

Besides these specific WTO agreements, various socio-economic factors associated with the current expansion of international trade have direct impacts on health as well. Poverty remains the main cause of ill health. Economic liberalisation, which the WTO facilitates, has contributed to unemployment, low wages and higher food costs. The environmental impacts of economic growth – climate change, deforestation, loss of agricultural land, desertification, air and water pollution – all have negative health impacts as well.

In many poorer countries, the major cause of ill-health and mortality is not infectious disease but simply hunger. Malnutrition causes death and disease. An adequate diet and clean water are probably the best drugs against many infectious diseases. Asks Dr Dorothy Logie of Medact, a UK lobby group of health professionals working to alleviate the threats to health of poverty, environmental degradation and violent conflict: “What is the point of immunising children if we’re then going to starve them?”

Sources: Koivusalo, M., *World Trade Organisation and Trade-Creep in Health and Social Policies*, GASPP Occasional Paper 4/1999, Helsinki, 1999, website: <http://www.stakes.fi/gaspp>; Rowson, M., “Globalization and Health-Some Issues”, *Medicine, Conflict and Survival*, Vol. 16, 2000, pp.162-174; Wallach, L. and Sforza, M., *Whose Trade Organization?*, Public Citizen, Washington, 1999, website: www.citizen.org.

Services liberalisation will result in the mass marketisation and privatisation of health, education, social care and other public and welfare services.

Publicly-funded healthcare carried out by the private sector is not a public good but a private subsidy.

tend not to operate in the countryside where health services have always been sparse.¹⁰⁵ As *The Economist* points out, “The poor in rural communities are unattractive clients for managed-care organisations, and may languish outside the new systems.”¹⁰⁶ Many “informal” or casual workers are also outside the public health system.

Yet private operators rely on the very state health and social services that they are undermining. They take trained and experienced staff from the state system, select patients whose needs the public services have already identified, offer only the (profitable) services they want to, and set up private facilities, ranging from laboratory analysis to residential care, which can be rented or contracted out to the public service. The WTO itself acknowledges that:

“private health insurers competing for members may engage in some form of ‘cream skimming’, leaving the basic public system, often funded through the general budget, with low-income and high-risk members. New private clinics may well be able to attract qualified staff from public hospitals without . . . offering the same range of services to the same population groups”.¹⁰⁷

In Brazil, the private sector can now offer 120,000 doctors for one-quarter of the population, whilst the public sector has fewer than 70,000 doctors for everyone else. As Public Services International concludes, such private health care “is never cheaper or more comprehensive than state care”.¹⁰⁸ The US is the most extreme example of this provision: it has the most administratively expensive health system in the world covering the lowest percentage of the population.¹⁰⁹

In India, under the influence of World Bank reforms, medical care has been handed over to the private sector without mechanisms to ensure the quality and standards of treatment. Infectious disease control programmes run by the state have been disrupted by being deprived of funds. Similar results have occurred in Sub-Saharan Africa.¹¹⁰

Private provision, in other words, is not an effective means to promote public health. Yet without good public health, the health of every individual is endangered.¹¹¹ As food policy analyst Tim Lang points out, many public health gains such as clean air, clean water and food safety were won once the affluent and the middle classes recognised that they could not escape the consequences of unhealthy conditions and that it was in their interests to tackle the causes of ill-health together.¹¹² Many of the pioneers striving for more and better housing in Britain, for instance, argued that housing improvements were not just a social right but also a health gain for all. As Geof Rayner of the UK Public Health Association points out, “a market-based approach to health not only drives up the costs of health care, but it can also lead to disinterest in the factors that make people ill. A consumer society promises – falsely – that medical technology can fix diseased individuals, and that good health can be bought and sold in the marketplace rather than being something to promote or work for.”¹¹³

Conclusion

By means of GATS, the WTO is stage-managing a new privatisation bonanza. Multinational and transnational corporations, including pharmaceutical, insurance and health care companies, are lobbying hard to capture the chunks of gross domestic product that governments currently spend on public services such as health and education. Revisions to GATS are by and large being proposed by trade negotiators from countries bent on obtaining better market access to export mar-

kets for domestic industries. Officials in other government departments responsible for health, agriculture or the environment may not be aware of what is being negotiated, nor the implications. Publicly-accountable services could be dismantled and the door effectively closed to ever reviving them.

A wide range of Southern governments, unions and NGOs contend that a thorough assessment, independent of the WTO and associated bodies such as the World Bank or IMF, of the health, social, environmental and cultural impacts of existing service liberalisation (and indeed of all the WTO agreements) must be conducted, with special reference to the poorest and to women, before negotiations continue on GATS. Some commentators believe that:

“it would be reckless for governments to expand the GATS before the full implications of existing provisions and current coverage have even been assessed or become widely known. Rather, the GATS policy implications should . . . be reviewed, assessed, fully debated and, where necessary, the agreement should be formed or rolled back. To expand such an agreement would be irresponsible.”¹¹⁴

Many British Members of Parliament, too, have called on the government to ensure that there is an independent and thorough assessment of the likely impact of the extension of GATS on the provision of key services, both in the UK and internationally.¹¹⁵ GATS itself mandates an assessment of trade in services, particularly of the impacts on developing countries (Article XIX), but the WTO Secretariat has done little so far towards this..

The African Group of countries believes that developing countries have already made “extensive concessions” without receiving sufficient benefits in return. The WTO Secretariat acknowledges that many developing countries signed on to GATS in 1995 without appreciating the Agreement’s full implications. Many of them have poorly-developed public services and made some wide-ranging commitments in the belief that foreign direct investment would step in to provide them. Several developing countries are arguing that they should not liberalise their service sectors further, but that the developed countries should reduce their subsidies and open up areas such as textiles and agriculture in which developing countries often have a comparative advantage.¹¹⁶ Developing countries have also pointed out that GATS outlines several clear specific and detailed rules to ensure the movement across borders of capital related to the supply of services, but nothing comparable concerning the movement of people (*see* Box, p.12)¹¹⁷

Public sector unions are calling for public services to be modernised and improved, but based on principles of democratic accountability, effective delivery, adequate funding, equality of access and fairness and partnership at work.¹¹⁸ The current ostensible “exclusion” of public services from GATS should be made actual for services provided in the public interest.

Opposition to GATS, however, should go hand-in-hand with support for campaigns against privatisation more broadly and generally. It would be a hollow victory for GATS to be curtailed only for bilateral and plurilateral arrangements with the same effects to increase (*see* Box, p.30) or for the IMF’s hold in the South to tighten. After all, many governments are already themselves restructuring public services; in several respects GATS is merely a mechanism for “locking-in” existing commercial practices. In Ecuador and Brazil, various groupings and coalitions of physicians, public health activists, trade unions and

The World Trade Organisation is one of the most important influences on health today.

Trade issues and TNC interests “will increasingly override public policy, distort planning, divert resources . . . marginalise social and human needs, impose new charges and create two-tier systems.”

Dexter Whitfield,
Public Services or Corporate Welfare,
Pluto Press, 2001.

If Not Multilateral, Then Bilateral

The Proliferation of Other Avenues

One aim of including services within the rules governing international trade was to improve upon the time-consuming, laborious and chaotic process of negotiating separate treaties bilaterally or regionally between countries. But the bilateral or regional approach has not only continued but proliferated from the EU to the Americas, Africa and Asia. When he was Vice President of the European Commission, Leon Brittan acknowledged in 1998 that the Commission was:

"using regional negotiations to open up the services economy in our partner countries . . . to the East, in the Mediterranean, with South Africa, with Mexico and the US.

Over 400 wide-ranging bilateral treaties have been agreed in the past two decades, but have largely evaded public scrutiny. The number of bilateral investment treaties quintupled in the 1990s from 385 in 1989 to 1,857 at the end of 1999. More than half of them (1,013) were between Western countries and developing or Central and Eastern European countries. Except for 11 between Western countries, the rest were concluded between Third World and Central and Eastern European countries.

The treaties are designed to ensure the security of foreign direct investments. The United Nations Conference on Trade and Development (UNCTAD) describes bilateral investment treaties as "the most important protection of international foreign investment" to date.

The main provisions of such treaties are not dissimilar from those of GATS or the abandoned OECD Multilateral Agreement on Investment (MAI). They usually cover the scope and definition of foreign investment; admission of investments; national and most-favoured nation status; fair and equitable treatment clauses; compensation guarantees for expropriation, war and civil

unrest; guarantees of fund transfers and the recuperation of capital gains; subrogation of insurance claims; and dispute settlement provisions.

US President Clinton said that the US-Uzbekistan treaty created "conditions more favorable for US private investment" and was designed to "protect US investment". The underlying goal would seem to be not to facilitate Uzbek investment in the US, but to enable US interests to extract raw materials more easily and take advantage of cheap labour.

The majority of treaties designate the World Bank's International Center for the Settlement of Investment Disputes (ICSID) as the arbitration body. This supra-national and private transnational organisation has the task of adjudicating virtually all investment disputes without democratic structures or transparency.

Deeper than GATS

The announcement of a bilateral trade deal between Singapore and Australia highlighted, according to the *Financial Times*, "the increasing view among some world leaders that the bilateral may be the best, even only, way to stimulate global liberalisation".

Indeed, a fervour for free trade agreements has been sweeping through the Asia-Pacific area with Australia, Canada, Chile, Japan, South Korea, Mexico, Singapore and New Zealand rushing to sew up a web of bilateral deals spanning the region. Asean (Association of South East Asian nations) leaders have proposed an ambitious free trade area with China, Japan and South Korea. Much of this activity is due to the WTO renegotiations being stalled, although many Asian governments also do not want to be left outside other trade groupings such as NAFTA, the EU and Mercosur (the South American customs union).

Of the proposed US-Singapore agreement, the President of the US Council of Service Industries, Robert Vastine, stressed that it "will be the basis for bilateral agreements with Chile and with other countries, and for services negotiations in the WTO

and in the FTAA [Free Trade Area of the Americas]". Vastine added that "a safeguard provision for services . . . would both be harmful and a bad precedent". Meanwhile, according to Member of the European Parliament Caroline Lucas, the EU is:

"completing a whole series of bilateral trade negotiations in which the services agenda goes far beyond anything even dreamed of in the GATS agreement".

The services liberalisation envisaged in these agreements not only goes much deeper than GATS but would also be implemented much faster. The EU's agreement signed with Mexico, for instance, has a larger scope than any other agreement the EU has ever concluded with a third country, and exceeds the services, investment and intellectual property provisions in the North American Free Trade Area (NAFTA).

The US and the EU have dominated the development of the WTO and have also led the trend by which countries get what they want through other means, using whatever avenue best suits their purposes, including numerous hard-to-scrutinise bilateral deals. As public service activist Dexter Whitfield points out, "states are bound up in a web of multinational trade and financial treaties, agreements and membership of regional and worldwide bodies."

Sources: Sorensen, N., "Bilateral Investment Treaties and Disputes", memo, Institute for Agriculture and Trade Policy, February 2001; McNulty, S., "Bilateral Trade Deals Gain Favour", *Financial Times*, 16 November 2000, p.17; de Jonquières, G., "Asian Ambition", *Financial Times*, 28 November 2000, p.24; Lucas, C., EU-Mexico Report, (mss), January 2001; Vastine, R., letter to USITR Barshefsky on US-Singapore FTA Negotiations, December 15 (no year given), website: www.uscsi.org/publications/papers/ustr.htm, accessed 24 March 2001; Whitfield, D., *Public Services or Corporate Welfare*, Pluto Books, London, 2001.

community groups resisting the privatisation of health care services and supporting alternatives to strengthen public services are working along similar lines to GATS critics. So are activists in other countries who stress that the public sector can be cheaper, as efficient, more flexible, more transparent and accountable than privatisation or public-private partnerships.¹¹⁹

International rules governing investment are certainly needed. The current set, however, and the way in which they are implemented, are invariably a charter for corporations to do as they please. Just because the World Trade Organisation, and indeed the World Bank and IMF, are doing the wrong job does not mean that international institutions are not needed to iron out the vast inequalities of the global economy or to prevent further meltdowns in financial markets. At issue is not whether to have rules governing international trade but what kind of rules to have and how they should be implemented so that they do not have adverse health, social and environmental impacts nor exacerbate inequities. As Kevin Watkins of Oxfam stresses, “We desperately need a rules-based system of global governance that places people before corporate profit, and shares the benefits of globalisation more equitably.”¹²⁰

Health is a fundamental human right, recently defined under the Covenant on Economic, Social and Cultural Rights: “all people have the right to the highest attainable standard of health . . . as a prerequisite for the full enjoyment of all other human rights”. Human rights and public health policies are indispensable. Trade policies, however, are negotiable.

Notes and References

1. Negotiations have also begun to change the Agreement on Agriculture (AoA). Since the 1947 General Agreement on Tariffs and Trade (GATT) governing trade in goods between those countries who signed the Agreement, there have been seven major GATT negotiation sessions: the Conference of Annecy, France, 1949; the Conference of Torquay, UK, 1950; the Conference of Geneva, 1956; the Dillon Round, 1962; the Kennedy Round, 1964-67; the Tokyo Round, 1973-77; and the Uruguay Round, 1986-94.
2. Public Services International, *The WTO and the General Agreement on Trade in Services: What is at Stake for Public Health?*, PSI, Ferney-Voltaire, France, 1999, p.5, website: www.world-psi.org, email: psi@world-psi.org.
3. “The European Union and World Trade”, *Frontier-Free Europe*, 1-4, August-September 1999, quoted in Price, D., Pollock, A.M. and Shaoul, J., “How the World Trade Organisation is Shaping Domestic Policies in Health Care”, *The Lancet*, Vol 354, 27 November 1999, pp.1889-1891, website: www.thelancet.com.
4. Vastine, R., statement before the Senate Finance Committee Subcommittee on International Trade, 21 October 1999, website: www.uscsi.org, accessed on 25 October 2000.
5. Public Services International, op. cit. 2, p.5. The estimate is calculated from WTO figures of national balance of payments records and thus represents cross-border trade. The value of services provided in one country by companies based in another (commercial presence) could be at least as large as cross-border trade. See “Opening World Markets for Services: A Guide to the GATS: The General Agreement on Trade in Services”, website: <http://gats-into.eu.int/gats-info/guide.pl?MENU=bbb>, accessed 1 November 2000.
6. European Services Forum, “Set of Principles”, 26 January 1999, website: www.esf.be/f_e_abou.htm
7. Office of the United States Trade Representative, “USTR 1998 Trade Policy Agenda and 1997 Annual Report”, USTR, Washington, DC, 2 March 1998, quoted in Price, D. *et al*, op. cit. 3.
8. *Human Development Report 1999*, UNDP, New York, p.3. If proposed GATS revisions go ahead, any government measure to encourage national or regional culture, including funding for national film boards, could be challenged.
9. European Services Forum, op. cit. 6.
10. Estimated from WTO Annual General Report, Geneva, 1998, cited in Balasubramaniam, K., “Globalisation & Liberalisation of Health care Services: WTO & the General Agreement on Trade in Services”, paper prepared for People’s Health Assembly, Dhaka, December 2000, website: www.pha2000.org.
The World Bank has calculated that in less developed countries, infrastructure development involving at least some private backing rose from US\$15.6 billion in 1990 to \$120 billion in 1997. Around 15 per cent of this was direct foreign investment in public schemes. See Roger, N., “Recent Trends in Private Participation in Infrastructure: Public Policy for the Private Sector”, World Bank Group, 1999, pp.1-4, note 196, quoted in Price, D. *et al*, op. cit. 3.
11. Vastine, R., op. cit. 4.
12. “Opening World Markets for Services: Towards GATS 2000”, website: <http://gats-info.eu.int/gats-info/g2000.pl?NEWS=aaa>, accessed 1 November 2000.
13. “Opening World Markets”, op. cit. 5.
14. After oil, tourism earns the most foreign currency for some 30 developing countries. But some 60 to 90 per cent of the money that tourists spend goes to transnational companies which own networks of airlines, hotel, tour operators and travel agents. See Seifert-Granzin, J. and Jesupatham, S., *Tourism at the Crossroads: Challenges to Developing Countries by the New World Trade Order*, Equations/Tourism Watch, Frankfurt, 1999; “Liberalising Tourism under the GATS: Pitfalls for Developing Countries”, “Notes on GATS”, (msss), Equations, Bangalore, May 2001, email <equations1@vsnl.com>; WWF, “Preliminary Assessment of the Environmental & Social Effects of Liberalisation in Tourism Services”, WWF International Discussion Paper, Gland, February 2001, website: www.panda.org, email: mperrin@wwfint.org
15. “Trade in Services Liberalisation and Gender Impacts in the European Union”, European Women’s Lobby, Brussels, September 2000, website: www.womenlobby.org
16. The GATS text is available at www.wto.org/english/tratop_e/serv_e/gatsintr_e.htm. See also WTO Secretariat, Trade in Services Division, *An Introduction to the GATS*, October 1999, website: www.wto.org/english/tratop_e/serv_e/gsintr_e.doc. For a range of articles and documents on GATS, see: www.xs4all.nl-ceo/gatswatch/gatswatch/html.
A WTO Council for Trade in Services is

- responsible for the workings of the GATS Agreement. It currently has three sub-groups: a Committee on Specific Commitments, a Working Party on Domestic Regulation and a Working Party on GATS Rules (emergency safeguards, subsidies, government procurement).
17. Air transport services are largely excluded from GATS, but a mandated renegotiation of the air transport Annex at least once every five years is expected to define these services more concisely so as to restrict exclusions. "The WTO approach . . . will mean a death sentence for airlines in developing countries" says one international air transport official. See Williams, F., "WTO Seeks to Spread its Wing Over Air Services", *Financial Times*, 29 September 2000, p.13.
18. Sinclair, S., *GATS: How the World Trade Organization's New "Services" Negotiations Threaten Democracy*, Canadian Centre for Policy Alternatives, Ottawa, September 2000, pp.24, 68, website: <http://www.policyalternatives.ca>; email: ccpa@policyalternatives.ca.
- One effect of not defining services is that more (as yet unthought of) services can be incorporated in future. GATS does define, however, "sector", "measures", "supply" and "person". A WTO guide to GATS identifies 11 broad service sectors, each divided into several sub-sectors:
- * Business (professional including legal, accounting, auditing, bookkeeping, architectural, real estate, engineering, medical and dental, veterinary, computer, management consultancy, advertising);
 - * Communication (telecommunications, postal, courier, audio-visual, radio, television, film, video, satellite);
 - * Construction and related engineering services;
 - * Distribution (retail, wholesale, franchising);
 - * Educational;
 - * Environmental (water delivery, refuse disposal, sewage, sanitation);
 - * Financial (insurance, reinsurance, underwriting, banking, provision of financial information, asset management);
 - * Health-related and social;
 - * Tourism and travel-related (travel agencies, tour operators, hotels, restaurants, catering, tourist guides);
 - * Recreational, cultural and sporting (entertainment, news agency);
 - * Transport (sea, water, air, space, rail, road, pipeline); and
 - * Other (including energy).
- Most WTO members used the WTO/UN classification system as the basis for scheduling commitments, but not the US. For the EU's interpretation of these services, see "Opening World Markets for Services: A Guide to the GATS: Which Sectors Are Covered by GATS?", website: <http://gats-into.eu.int/gats-info/guide.pl?MENU=ccc>, accessed 1 November 2000.
19. "Opening World Markets", op. cit. 12.
- The International Chamber of Commerce stresses that manufacturing industries are infused with services from beginning to end: research and development, inventory management and control, transport, marketing, advertising, insurance, and "backroom" functions, such as accounting and legal services. Likewise, agriculture requires research and development, finance, insurance, storage, transport, distribution, marketing, and a host of technical services. See website: <http://www.iccwbo.org/>
20. The WTO Secretariat states that "the fact that the GATS rules are still necessarily untested, and that the services schedules are much more complex than those for goods, adds to the difficulty of assessing exactly what rights and obligations WTO members have assumed under the services package". See WTO Secretariat, op. cit. 16.
21. WTO, "The GATS: Objectives, Coverage and Disciplines", website: www.wto.org/english/tratop_e/serv_e/gatsqa_e.htm
- The "supply" of a service includes its delivery, production, distribution, marketing and sale.
22. The WTO website lists each country's Schedules of Specific Commitments: http://www.wto.org/english/tratop_e/serv_e/22-specm_e.htm. The GATS text itself (see ref. 16) explains how to read a schedule. More accessible is the EU's information point on world trade in services which enables commitments to be viewed by country or by service sector, website: <http://gats-info.eu.int>.
- The WTO Secretariat has identified over 1,400 errors and inconsistencies made by governments in scheduling their commitments. Such errors would become more significant if the agreement was expanded. See Gould, E. and Joy, C., *In Whose Service? The Threat Posed by the General Agreement on Trade in Services to Economic Development in the South*, World Development Movement, London, December 2000, p.16, website: www.wdm.org.uk.
- Canada believed it had protected from GATS its 1965 national trade agreement (Auto Pact) to encourage domestic car manufacturing, but the WTO ruled otherwise in May 2000. See Sinclair, S., op. cit. 18, pp.42-43.
- More than 70 WTO members, mainly Northern countries familiar with the system, have listed many exemptions to the Most-Favoured Nation clause. But in a US challenge arguing that the EU's preferential banana import arrangement with Caribbean countries discriminated against US "service providers" involved in banana distribution, a WTO dispute panel ruled that the EU's arrangement contravened GATS — the EU had forgotten to list it as an exception to the MFN clause. See Sinclair, S., op. cit. 18, pp.48-49.
23. WTO Secretariat, "Recent Developments in Services Trade", 9 February 1999, S/C/W/94, website: <http://docsonline.wto.org>, quoted in Gould, E., "The 2001 GATS Negotiations: The Political Challenge Ahead", *The Alliance for Democracy*, March 2001, website: www.thealliancefordemocracy.org/campaigns/2000.
24. Hartridge, D., "Opening Markets for Banking Worldwide: The WTO General Agreement on Trade in Services", speech to international banking seminar, 8 January 1997, London, UK, quoted in Gould, E., "The WTO General Agreement on Trade in Services: Separating WTO FACT from FICTION", Council of Canadians, website: www.canadians.org, received May 2001.
25. Lal Das, B., "Negotiations in Agriculture and Services in the WTO: Suggestions for Modalities/Guidelines", paper presented at "Current Developments in the WTO: Perspective of Developing Countries", Third World Network seminar, Geneva, 14-15 September 2000.
- Many of the deregulatory and privatisation aspects of GATS are similar to the structural adjustment measures imposed on developing countries by the IMF and World Bank.
26. Caplan, R., *GATS Handbook*, Alliance for Democracy, Waltham, Massachusetts, website: <http://www.thealliancefordemocracy.org/>, accessed 24 February 2001.
27. For example, a WTO dispute panel decided in 1996 that a US ban of gasoline imports from Brazil and Venezuela because they did not meet its Clean Air Act standards contravened GATT rules. In September 2000, however, a WTO dispute panel upheld a French ban on imports of "white" asbestos, challenged by Canada — the first time that a trade-restrictive measure has been exempted from WTO rules on health grounds. In March 2001, moreover, the WTO's appeals body ruled that a product's health risk was a legitimate factor in determining whether it was "like" another product.
- See Waskow, D. and Yu, V.B., *A Disservice to the Earth: The Environmental Impact of the WTO General Agreement on Trade in Services (GATS)*, Friends of the Earth US, Washington, June 2001, website: <http://www.foeurope.org/trade/wto/wto.htm>
28. Sinclair, S., op. cit. 18, p.1.
- GATS Articles XIV and XIV bis provide for general exceptions and more specific national security exceptions. The Article XIV exemption for measures "necessary to protect human, animal or plant life or health", is borrowed from GATT (Article XX), but leaves out an additional GATT exemption for measures "relating to the conservation of exhaustible natural resources", an omission from GATS which could be interpreted as intentional. Article XIII provides exceptions for government procurement from most-favoured nation, market access and national treatment principles, but not transparency.
29. For details of laws in countries of the South which could be threatened by GATS rules of national treatment and market access, see Gould, E. and Joy, C., op. cit. 22, pp.10-12.
30. Sinclair, S., op. cit. 18, pp.1, 6, 40.
- The term "measure" is a broad one. It covers any law, regulation, rule, procedure, decision or administrative action taken by central, regional or local governments and authorities and non-governmental bodies exercising powers delegated to them by these governments and authorities. GATS could therefore restrict the ability of governments to use subsidies and grants; nationality requirements; labour standards; residency requirements; licensing standards and qualifications; registration agreements; performance measurements; technology transfer provisions; local content or employment provisions; economic quotas or needs tests; licensing or training requirements; restrictions on ownership of property or land; limitations on access to markets; environmental and consumer protection measures; and some tax measures. See also p.X on domestic regulation.
31. Hartridge, D., op. cit. 24.
32. "Opening World Markets", op. cit. 5.
33. The Multilateral Agreement on Investment (MAI) was negotiated among the 29 industrial country members of the Organization for Economic Cooperation and Development (OECD) from 1995 until 1998, when negotiations were abandoned because of widespread citizen opposition. As many features of the GATS renegotiations resemble aspects of the MAI, the issues raised by GATS are similar to those underlying the MAI: loss of sovereignty on the part of nation-states; loss of governments' ability to protect the social security system and national culture; and doubts about the future of public services in a context of trade and investment liberalisation. Rules on investment may also be negotiated elsewhere, for instance, the TRIMS agreement. See Khor, M., "The WTO and the Proposed Multilateral Investment Agreement:

- Implications for Developing Countries and Proposed Positions”, Third World Network, Penang, (undated); *MAIgalomania*, Corporate Europe Observatory, Amsterdam, February 1998; *License to Loot: The MAI and How to Stop It*, Friends of the Earth, Washington, 1998; Clarke, T. and Barlow, M., *MAI: The Multilateral Agreement on Investment and the Threat to Canadian Sovereignty*, Stoddart Publishing, Toronto, 1997.
34. Ruggiero, R., “Towards GATS 2000—A European Strategy”, address to the Conference on Trade in services, organised by the European Commission, 2 June 1998, Brussels, cited in Gould, E. and Joy, C., op. cit. 22, p.4.
35. Sinclair, S., op. cit. 18.
36. WTO, op. cit. 21.
37. “There is not a single empirical study analysing on a comprehensive basis – across countries, sectors and modes – the effects on services trade attributable to scheduled commitments”. See WTO Secretariat, op. cit. 23.
- Such statistics were also missing from the Uruguay Round. See Raghavan, C., *Recolonisation: GATT, the Uruguay Round and the Third World*, Zed Books, London, 1990.
38. At the conclusion of the Uruguay Round, it was agreed that negotiations had to continue immediately on a number of service sectors: financial, maritime transport and basic telecommunications services and on the movement of natural persons supplying services. These led to various Annexes. The Annex on Financial Services, which came into force in January 1999, removed many obstacles for financial services corporations wanting to enter “emerging markets”. It is predicted to liberalise over 90 per cent of the world market in insurance, banking and brokerage services. See Corporate Europe Observer, no 4, July 1999, “Special WTO Edition”, website: <http://www.xs4all.nl/~ceo/observer4/index.html>, accessed 24 February 2001.
- The Annex on telecommunications established the right for any service supplier to have access to and make use of public telecommunication networks and services (telephone, telegraph, telex and data transmission, but not radio or television) on reasonable and non-discriminatory terms.
39. Gould, E., “The Next MAI”, Fall 1999, Council of Canadians, website: www.canadians.org, accessed 25 October 2000.
- The WTO Secretariat stated in 1999: “The GATS rules are not quite complete, and are largely untested. The process of filling the gaps will require several more years of negotiations . . . Among the most important elements in the GATS package is the promise that successive rounds of negotiations will be undertaken to continue opening up world trade in services”. See WTO Secretariat, op. cit. 16.
40. WTO Secretariat, op. cit. 16.
- Former WTO Services Director David Hartridge said, “It [GATS] has a built-in commitment to continuous liberalization through periodic negotiations, a far more solid commitment than the old GATT ever had.” See Hartridge, D., op. cit. 24.
41. Brittan, L., “European Objectives For Services Worldwide: How the WTO Can Help”, speech, 2 June 1998, Brussels, website: <http://gats-info.eu.int/gats-info/gnews.pl?NEWS=ccc>, accessed 1 November 2000.
42. Speech to the US Council for International Business, New York, 8 June 2000, website: http://europa.eu.int/comm/trade/speeches_articles/spla23_en.htm
43. Negotiators aim to reclassify services by:
- narrowing the description of service sub-
- sectors in which governments have made the least number of commitments (such as health, education and social services) and broadening that of those in which members have made the greatest number;
- disaggregating services to make it easier for countries to demand or to offer access to a particular sub-sector;
 - clustering related services together so that a country’s specific commitment applies to the whole group rather than just one sector;
 - reclassifying new services so that they are encompassed by existing commitments.
- Hospital management, for instance, could be reclassified under business services and thereby hived off from health-related service sectors in which WTO members have not made many commitments. Or health information systems could be classified under “computer and related services” instead of “health-related and social services”. Or ancillary services such as catering, laundry and cleaning could be classified not under health services but elsewhere. The EC has proposed that water supply should be considered part of an environmental services “cluster”, while the US has argued that all energy-related services should be treated as a cluster. These reclassifications would affect the interpretation of existing commitments as well as future commitments. Canadian researcher Scott Sinclair regards service reclassification, a seemingly simple technical procedure, as a means “to expand GATS coverage by stealth”. See Sinclair, S., op. cit. 18, pp.67-71; Gould, E., op. cit. 24.
44. Some commitments could be negotiated which would apply to all members, sectors and/or modes of supply, for instance, each government could make a minimum level of commitments in each sector; countries could include under GATS a specified percentage of their services by GDP; governments could reduce limitations in their schedules by a fixed percentage; or members could eliminate certain measures such as residency requirements in certain sectors or modes.
45. UK Department of Trade and Industry, “GATS 2000, Health and Education Services”, briefing note, 2 December 1999, cited in Pollock, A.M. and Price, D., “Rewriting the Regulations: How the World Trade Organisation Could Accelerate Privatisation in Health-Care Systems”, *The Lancet*, Vol. 356, 9 December 2000, p.1996. See also website: <http://www.dti.gov.uk/worldtrade/service.htm>
46. Many governments might prefer to be able to make concessions in one agreement, for instance, the Agreement on Agriculture, in return for concessions in another agreement, such as the TRIPs agreement, instead of negotiating an agreement such as GATS on its own. The world’s three leading service industry organisations (the US Coalition of Service Industries, the European Services Forum and the Japan Services Network) called on their governments in May 2001 to launch a new round of WTO renegotiations on the grounds that substantial agreement on services would most likely be achieved in the context of a wider and broad-based WTO round.
- The Council of Trade in Services finally agreed guidelines and procedures in March 2001 for the rest of the GATS 2000 negotiations, having agreed to various requests from developing countries. But no completion dates were set. Countries now enter the more detailed “request-offer” phase: countries request each other to liberalise a particular service under GATS and respond with offers of their own. Southern countries will more often be
- the “requestee” rather than the “requester”. Bilateral trade-offs are then extended on a most-favoured nation basis to all WTO members. The US and European Communities have already submitted their initial negotiating proposals for specific service sectors; see website: www.wto.org/ddf/ep/. See also Raghavan, C., “Revised GATS Guidelines Attempt to Mollify Developing World”, *Third World Economics*, no 254, 1-15 April 2001, pp.2-4.
47. The WTO has made some original WTO documents public on its website: <http://docsonline.wto.org>, and, because of criticism, has started to post many of its new documents. For a range of articles and documents on GATS, including WTO documents not made public, see: www.xs4all.nl/~ceo/gatswatch/gatswatch/html; and Gould, E., op. cit. 24.
48. CSI members are drawn from the insurance, financial, telecommunications, travel, transportation and air cargo, information technology and internet, energy, management consultants, entertainment and retail distribution sectors. Vastine says that the group “played an aggressive advocacy role in writing the General Agreement on Trade in Services”. The objectives of all government regulation, according to CSI, should simply be to promote fair competition. In 1998, CSI set up a working group to prepare for the GATS negotiations which “has continued to work with the WTO, the USTR [US Trade Representative], Congress, the diplomatic community in Washington, and international organizations to influence the current services negotiations.”
49. Vastine, J. R., statement before the Interagency Trade Policy Staff Committee, 19 May 1999, website: www.uscsi.org, accessed on 25 October 2000.
50. Vastine, R., op. cit. 4, emphasis added.
51. Ibid.
52. “Opening World Markets”, op. cit. 12.
53. “Opening World Markets for Services: A Guide to the GATS: What GATS Means to Business”, website: <http://gats-into.eu.int/gats-info/guide.pl?MENU=aaa>, accessed 1 November 2000.
- While the US and EU may agree on wanting other countries to open up more of their service sectors to competition, they disagree when it comes to their own sectors. For instance, the US is now “seeking to gain greater access to European markets, particularly for satellite transmissions, pay-TV networks, and the newest media”. But the EU claims that the European film industry has undergone a dramatic decline because of competition with US producers. France insists on restricting imports of US films, television programmes, music and videos. To date, the EU has not made any market access commitments in the audiovisual sector and has listed comprehensive most-favoured nation exemptions. See “Opening World Markets”, op. cit. 18.
- The US is frustrated that the EU will not allow, on precautionary health grounds, the import of meat from cattle which have been given hormones, despite a WTO ruling. The US has therefore increased import tariffs on EU goods unconnected with the disputed practice. See also ref. 22. The US, meanwhile, has not changed its tax legislation governing a Foreign Sales Corporation (FSC), despite a WTO ruling that its provisions are in effect export subsidies, which are prohibited by WTO rules, and should be withdrawn by 1 October 2000.
- The US and EU have also disagreed over a plan for US and EU regulators to recognise

- each other's certification procedures for the safety of six types of industrial product including computers, telecommunications equipment and other electronic devices. See "It's Not Mutual", *Financial Times*, editorial, 13 November 2000, p.24; Alden, E., "Mismatch on Product Safety Puts Accord on Danger List", *Financial Times*, 9 November 2000, p.23; website: www.europa.eu.int/com/trade
54. "Opening World Markets", op. cit. 12.
55. European Services Forum, website: www.esf.be/
56. European Services Forum, op. cit. 6.
57. See World Services Congress 1999, website: www.worldservicescongress.com. quoted in Sinclair, S., op. cit. 18.
58. Website: <http://www.uscsi.org/events/services2000conf.html>, accessed 24 March 2001.
59. Cohen, N., "Brussels Puts Everything Up For Sale", *New Statesman*, 2 April 2001; European Services Forum website: <http://www.esf.be/>.
The Trade Directorate of the EU has created a special electronic mail list serve ("Services Information System") through which it distributes draft EU GATS negotiating proposals to solicit business comments and suggestions. See Wesselius, E., "GATS: Undermining Public Services World-wide", mss, CEO/TNI, Amsterdam, May 2001, website: <http://www.xs4all.nl/~ceo/gatswatch/>
60. The WTO's Council for Trade in Services commented in November 1999 that exceptions provided in Article I.3 needed to be "interpreted narrowly" when applied to health services. Council minutes are used by dispute panels to interpret WTO agreements. See "GATS and Public Service Systems: The GATS 'Governmental Authority' Exclusion", discussion paper from international branch of the Ministry of Employment and Investment, Government of British Columbia, Canada, 2 April 2001. website: www.ei.gov.bc.ca/Trade&Export?FTAA-WTO or http://members.iinet.net.au/~jenks/GATS_BC2001.html; and Krajewski, M., "Public Services and the Scope of GATS", Center for International Environmental Law, Geneva, May 2001, website: www.ciel.org
61. See Martin, B., *In the Public Interest? Privatisation and Public Sector Reform*, Zed Books, London, 1993; Hildyard, N., *The World Bank and the State: A Recipe for Change?*, Bretton Woods Project, London, 1998.
62. Public Services International, *Health and Social Services*, PSI, Ferney-Voltaire Cedex, 1999, p.9. For details of the mechanisms by which public services in Britain have been marketised over the past two decades, see Whitfield, D., *Public Services or Corporate Welfare; Rethinking the Nation State in the Global Economy*, Pluto Books, London, 2001; Centre for Public Services, "What Future For Public Services?" Private Finance Initiative and Public Private Partnerships", June 2001, website: www.centre.public.org.uk/briefings, email <ctr.public.serv@mcr1.poptel.org.uk>
63. Hall, D., *Globalisation, Privatisation and Health care-A Preliminary Report*, Public Services International Research Unit, Greenwich, January 2001, p.17, website: www.psiru.org.
64. Under the North American Free Trade Agreement (NAFTA), for instance, US for-profit hospitals argued that the user fees charged by the Canadian public health system to patients were commercial charges and that denying US companies entry to the Canadian health market was a denial of the right of US companies to profit from that market. European trade officials, moreover, have emphatically reassured WTO members that an exemption for governmental services in the European Treaty had offered no protection at all in practice. See Gould, E., op. cit. 24.
Article XIII of GATS currently exempts government procurement – the services a government buys directly for its own use – from the obligations of most-favoured nation, market access and national treatment. The European Services Forum proposed in 1999 that this article be deleted or that the WTO Agreement on Government Procurement covering goods be extended to services. The EU estimates that government procurement may cover as much as 15 per cent of European GDPs. See European Commission, Directorate General I, Seattle Conference Preparations, website: <http://www.europa.eu.int/com/dg01.newround/seaproc.htm>, accessed 5 June 1999, cited in Koivusalo, M., *World Trade Organisation and Trade-Creep in Health and Social Policies*, GASPP Occasional Paper4, 1999, Helsinki, 1999, website: <http://www.stakes.fi/gaspp>
65. Public Services International, *Transnationals in Public Services*, PSI, Ferney-Voltaire Cedex, 1998, p.3. website: www.world-psi.org
66. "Opening World Markets", op. cit. 18.
The "market" for "environmental services" is significant. One-fifth of the world's population has no access to clean water and two-fifths have no acceptable means of sanitation, according to WHO and Unicef. But many are unlikely to be a target for utility companies because they are unlikely to be able to pay for these services. See Williams, F., "Many in Developing World 'Still Lack Clean Water and Sewerage Services'", *Financial Times*, 23 November 2000, p.12.
67. Hall, D., *The Water Multinationals*, PSIRU, Sept, 1999, website: www.psiru.org/reports/9909-W-U-MNC.doc.
68. quoted in "Don't Gamble With Canada: Don't Gamble With Public Education!", The Council of Canadians, website: www.canadians.org.
The UK has already laid the groundwork for commercialisation of higher education. See Nunn, A., "GATS and Resistance: The Case of UK Higher Education and Knowledge-Based Restructuring in an International Context", (mss), email <alexandernunn@hotmail.com>; People and Planet, *The Threat to Higher Education*, Oxford, 2000, website: [www.peopleandplanet.org/tradejustice/GATS; Education International/Public Services International, The WTO and the Millennium Round; What is at Stake for Public Education?, EI-PSI, Brussels/Ferney-Voltaire Cedex, website: \[www.ei-ie.org/pub/english/epbeipsiwt.html\]\(http://www.ei-ie.org/pub/english/epbeipsiwt.html\), accessed 1 November 2000; Oxfam, *Break the Cycle of Poverty*, Education Now, Oxfam, 1999, <http://www.oxfam.org/educationnow>.
Corporations have also moved into school classrooms by providing computers and text books. Banks send CDs and games that teach personal finance; other companies send free exercise books displaying advertising from soft drink companies and sportswear groups. As the head of telecoms company said, "We get the reputation for being a good corporate citizen. But it's not an esoteric holier-than-thou thing. We're in business." Commercial companies are also involved in education under the Private Finance Initiative \(PFI\). Nearly 20 per cent of the £9 billion committed by the British government since 1997 to rebuild schools is earmarked for schemes under PFI. Companies are also providing teachers, and proposals have been made for the for-profit sector to run schools directly. See Baby Milk Action, *Seeing Through the Spin* \(Schools Pack\), website: \[www.babymilkaction.org\]\(http://www.babymilkaction.org\); Mathiason, N., "Can Schools Survive Commercial Drive?", *The Observer*, 11 February 2001, p.5; Regan, B., *Our Schools Are Not For Sale: The Case Against Privatisation of Education*, Socialist Teachers Alliance, 2001.](http://www.peopleandplanet.org/tradejustice/GATS; Education International/Public Services International, The WTO and the Millennium Round; What is at Stake for Public Education?)
69. Pollock, A.M. and Price, D., op. cit. 45, p.1996.
70. Calculated by Allyson Pollock from 1999 data.
71. Public Services International, op. cit. 62, p.4.
72. Hall, D., op. cit. 63, p.5.
73. Pollock, A. and Price, D., op. cit. 45, p.1999.
74. Koivusalo, M., op. cit. 64.
75. The multinational expansion of private health care companies has not been as coherent or extensive as that of other public service sectors such as water, waste management and energy. But companies active in insurance, hospitals, laboratories (clinical diagnosis and therapy such as dialysis and MRI scans) and support (cleaning and catering) services all have an impact on health care services. Support service multinationals with many contracts in hospitals in many countries include ISS (Denmark), Sodexho (France), Rentokil/Initial (UK), Granada/Compass (UK) and EDS (US). Some of the main multinational companies involved in health insurance include Aetna (Netherlands), Allianz (Germany), Aon (US), CIGNA (US), UnitedHealth care International (US) and AIG (US). In the UK, Bupa and PPP have 70 per cent of the health insurance market. Among the largest for-profit chains of hospitals are Hospital Corporation of America (HCA), Sun Health care (US), Tenet (US), Humana (US) and National Medical Enterprises (NME) (US).
Private health care companies, particularly US ones, are targeting countries which have a sufficiently affluent elite willing to pay for health care or which have an existing private health service base. Countries and regions of special interest are Latin America, South-East Asia, China and the Pacific Rim, the Middle-East and, to some extent, in South Asia. See Koivusalo, M., op. cit. 64; Price, D., Pollock, A.M. and Shaoul, J., op. cit. 3; Hall, D., op. cit. 63.
76. Pollock, A.M. and Price, D., op. cit. 45, p.1996.
Health-related services include not only professional and clinical services (hospitals and doctors) but also insurance, occupational, laboratory, infrastructure, support, nursing, community care and pensions services.
77. WTO Secretariat, "Health and Social Services: Background Note by the Secretariat S/C/W50", 18 September 1998.
State involvement in health care is usually based on compulsory social insurance or general taxation.
78. WTO Secretariat, op. cit. 77.
Hospital services represent between 40-50 per cent of this expenditure, pharmaceuticals between 30-40 per cent and out-patients the remainder. OECD countries account for about 90 per cent of worldwide health care expenditure. The public share of total health spending in the US is 45 per cent, lower than any other industrial country. The OECD average is about 75 per cent.
79. Ibid.
GATS schedules list several categories of health services divided into three areas:
- professional services, encompassing medical, dental, veterinary, nursing and midwives, laboratory, services;
- health-related and social services,

- encompassing hospital, other human health, social, community care (including of the elderly) and other services;
- health and pensions insurance.
80. Ibid.
81. Ibid; EU, op. cit. 22.
The WTO Secretariat points out that 19 of the 59 countries that have made commitments on medical or hospital services have not made commitments on health insurance services, while 35 of the 76 members with commitments on health insurance have not made commitments on medical or hospital services.
82. Kuttner, R., "The American Health Care System: Wall Street and Health Care", *New England Journal of Medicine*, 340, 1999, pp.664-68.
83. Website: www.uscsi.org.
84. Gould, E., op. cit. 39.
85. This is despite the fact that Canada has not made any commitments under GATS to liberalise professional, health or social services. See Sanger, M., *Reckless Abandon: Canada, the GATS and the Future of Health Care*, Canadian Centre for Policy Alternatives, February 2001, website: www.policyalternatives.ca
86. See Pollock, A.M. and Price, D., op. cit. 45.
87. A cross-subsidy equivalent in the commercial world is "loss leaders": selling something at less than cost price to draw in customers, but with the costs paid for by other higher-priced goods.
88. Pollock, A.M. and Price, D., op. cit. 45, p.1996. See also Evans, R., "Health Reform: What Business is it of Business?" in Drache, D. and Sullivan, T., (eds), *Health Reform: Public Success, Private Failure*, Routledge, London 1999, pp.25-47.
A general principle to ensure equity in health care has been to provide services according to need and to finance them according to ability to pay. A comparison of different finance mechanisms suggests that general taxation and public provision is the least regressive approach, while financing health care services through private insurance and patients' out-of-pocket payments is the most regressive. Universal social insurance, such as is common in continental Europe, falls somewhere in the middle. The privatisations in Britain of utilities (electricity, gas, water), transport and long-term care have adversely and disproportionately affected the poor, elderly, disabled and unemployed. See Koivusalo, M., op. cit. 64; Pollock, A. and Price, D., "Globalisation? Privatisation!" *Health Matters*, 41, Summer 2000. website: <http://www.healthmatters.org.uk/stories/>
89. Kuttner, R., "Columbia/HCA and the Resurgence of the For-Profit Hospital Business", *New England Journal of Medicine*, 335 (5), 1 August 1996, pp.362-367.
90. GATS could also enable pharmaceutical companies to run hospitals. In the US, the pharmaceutical industry, one of the most profitable and fastest-growing sectors of the world economy, is integrating vertically into managed care companies (those that act as an intermediary between doctor and patient) and other services. Merck, for example, has acquired Medco, the largest US prescription drugs provider. Zeneca, the world's second largest manufacturer of cancer drugs, has taken over the management of 11 cancer treatment centres in the US.
Meanwhile, the confidentiality of medical records could be undermined. For instance, a country may not have opened up its health services to competition under GATS, but may have opened up data processing or database services. Would national measures relating to the confidentiality of health records be classified under health services or under database services? See Sinclair, S., op. cit. 18, pp.36-37. See also Sanger, M., op. cit. 85.
91. Allaert, B. and Forman, N., "Gender, Trade and Rights: Moving Forward", *WIDE Bulletin*, Brussels, May 1999; Macdonald, M., "From Seattle to Beijing+5: How Can Women's Economic Human Rights be Safeguarded in Times of Globalisation? The Impact of Macroeconomy on Women," *WIDE Bulletin*, Brussels, December 2000, website: www.eurosur.org/wide/porteng/htm. See also Zarilli, S. and Kinnon, C. (eds.) *International Trade in Health Services: A Development Perspective*, UNCTAD/WHO, June 1997.
92. Butler, P., "Dirty Work", *Guardian Society*, 2 August 2000, pp.10-11.
93. Ibid.
94. Ibid.
95. The Care Standards Act provides for regulation of children's homes, independent (not NHS) hospitals, independent clinics, care homes, residential family centres, independent medical agencies, domiciliary care agencies, fostering agencies, nurses agencies and voluntary adoption agencies.
96. Ennals, R., "A Very Messy Business", *Health Matters*, issue 42, Autumn 2000.
The detailed rules and regulations have still to be worked out; the largest group of those being consulted are those hospital groups and medical bodies whose employees and members were responsible for the tragedies in the first place. Separate quality controls for public and private medicine could reinforce a two-tier health care system.
97. Saltman, R., "The Sad Saga of Managed Care in the United States", *Eurohealth* 4, 1998, pp.35-36, quoted in Koivusalo, M., op. cit. 64.
98. Quoted in "Failure to Stop Health Care Privatization in New Deal Increases Likelihood of Trade Attacks", press release, 11 September 2000, The Council of Canadians, Ontario. website: www.canadians.org.
A 1997 study in the *New England Journal of Medicine* analysing 1994 data of over 5,000 acute care hospitals in the US found that for-profit hospitals were 25 per cent more expensive than non-profit facilities. A 1999 report, *Private Profit or Public Good: The Economic and Politics of the Privatization of Health Care*, from the Parkland Institute at the University of Alberta, Canada, concluded that private, for-profit health care consistently fell short of non-profit and publicly-provided health care in various countries over several decades. A July 1999 study, "Quality of Care in Investor-Owned vs Not-for-profit HMOs" in the *Journal of the American Medical Association* by Dr. Sidney Wolfe and Dr. David Himmelstein examined 1996 quality of care data from 248 investor-owned and 81 not-for-profit HMOs providing coverage in total to 56 per cent of all Americans in HMOs. For all 14 quality indicators, for-profit HMOs scored lower than non-profit ones. Although the patient treatment costs in both type of HMO were almost identical, spending on administration and profits was 48 per cent higher in for-profit HMOs. Concluded Dr. Himmelstein, "If all American women were enrolled in for-profit HMOs instead of non-profits, 5,925 more would die [each year] from breast cancer . . . Your chances under a for-profit HMO are much worse if you are seriously ill."
As important as quality of care, however, is the range of health care services provided: for-profit facilities tend to develop care only in those areas which make money, avoiding long-term care in areas such as burns or asthma. As the driving forces in health care become profit and avoidance of responsibility, the non-profit sector is starting to avoid long-term patients as well.
99. "A radical critique of medicine has to deal with the things that make people sick and the kind and quality of health care people get". See Levins, R., op. cit. 97.
100. Public Services International, op. cit. 62, p.9.
101. Whitfield, D., op. cit. 62, p.29.
102. Kuttner, R., op. cit. 82; Kuttner, R., op. cit. 89; Kuttner, R., "The American Health Care System: Health Insurance Coverage", *New England Journal of Medicine*, 340 (2), 1999, pp.163-168; Kuttner, R., "The Commercialization of Prepaid Group Health Care", *New England Journal of Medicine*, Vol. 338, No. 21, pp.1558-1563; "Health Care: Thirty-Six Places to Go", *The Economist*, 24 June 2000, pp.72-73.
Before the 1990s, a "fee for service" system dominated: doctors and hospitals recouped expenditure from insurers, which recovered their costs from their clients' employers, who passed this cost onto the public in their products. Since the 1990s, however, the concept of managed care was introduced to contain costs and is replacing the fee system. Managed care is health services provided under the administrative control of large, private (mostly for-profit but many originally mutual) organisations charging flat fees per patient enrolled per month. Employers have begun to purchase pre-paid arrangements based on inclusive "managed" arrangements, while public health efforts have been dismantled to make way for them. Prepaid group health care plans began in the US in the 1940s as a social form of health care, some originating in occupational health schemes. In the early 1970s, national legislation enabled such plans to become for-profit health maintenance organisations (HMOs). Today, nearly three out of four HMOs (now generally called managed care organisations) are for-profit, shareholder-owned plans run by non-clinicians preoccupied with holding down costs. The conflict of interest between a plan's desire to save money and a patient's need for good care has been described as "managing costs" versus "managing care". This industrialisation of US health care has turned the system from one run by the professions into one run by insurance companies managing the professions and telling them what kind of health care they can offer.
103. The US spends more than any other country on health care in absolute terms and as a proportion of GDP. It accounts for 3-4 per cent of the world's population, yet spends 35-40 per cent of the world's spending on health care. Despite its high expenditure of health care, however, the US has some of the worst health indices of OECD countries. Increased spending does not mean increased health or health care: one-fifth of the spending is on administration; those who need health care do not receive or have access to it; the spending is driven by a technological model of health and medical consumerism; and the underlying causes of sickness are increasing. "The irrationality of the system extends even to the rich," points out Richard Levins, "who are over-treated". Nearly 200,000 people in the US die each year through improper medical interventions, while many more die from misuse of heavily-advertised prescription drugs, over-the-

counter remedies and other preparations. See Levins, R., "Is Capitalism a Disease? A Report on the Crisis in US Public Health, *Monthly Review*, Vol. 52, No. 4, September 2000, pp.8-33.

104. The US health care system is financed by insurance, although programmes and companies vary from state to state. For nearly two out of three Americans, this health insurance is paid for by their employers. Publicly-funded national insurance schemes, paid for out of national and state budgets, were introduced in 1965, modelled on private health insurance schemes and based on the needs of doctors and hospitals rather than patients. Medicare pays for hospital and doctor treatment (but not drugs outside hospitals) for some 39 million people over the age of 65, while Medicaid pays for some 34 million people on low-incomes or with disabilities. But today, the vast majority of the 44 million uninsured are employed. More than one-third of Hispanics and one fifth of blacks do not have regular insurance, compared with 12 per cent of white Americans. Despite state-sponsored insurance programmes, America's poor have little access to medical care of any sort. Moreover, the number of people who are underinsured is growing as employers cut back on their costs. Like the uninsured, they pay for care themselves out of pocket or forego it. Medicare and Medicaid have insufficient resources to check that treatment is necessary or that bills are accurate. The US Department of Health estimates that it overpays private hospitals \$23 billion a year. Medicare and Medicaid together underwrite about three-quarters of the costs of the \$86 billion long-term care industry. See *The Economist*, op. cit. 102.
105. Hsiao, W., Director of Harvard School of Public Health, reported in *New York Times*, 17 June 1999, cited in Public Services International, *Great Expectations: The Future of Trade in Services*, PSI, Ferny-Voltaire-

Cedex, February 2000, website: <http://www.world-psi.org>

106. "The Americas Shift Toward Private Health Care", *The Economist*, 8 May 1999, pp.69-70.
107. WTO Secretariat, op. cit. 77.
108. Public Services International, op. cit. 62, p.10.
109. Ibid., p10.
110. Price, D., Pollock, A.M. and Shaoul, J., op. cit. 3.
111. Public Services International, op. cit. 62, p.16
112. Lang, T., "The New GATT Round: Whose Development? Whose Health?", *Journal of Epidemiology and Community Health*, November 1999; Lang, T., "Trade, Public Health and Food" in McKee, M., Garner, P. and Stott, R., (eds), *International Co-operation and Health*, Oxford University Press, Oxford, 2001 (forthcoming).
113. Rayner, G., personal communication, 11 June 2001.
No amount of expenditure of health care will solve health problems caused by rising rates of diabetes explained by a higher consumption of high-fat, high calorie, fast food and sugary drinks, declining rates of exercise or extended hours of sedentary entertainment. The explosion of obesity in the US, Britain and Germany, however, will result in a massive increase in health costs over the next 20 years.
If broader measures of health are the goal, spending more on housing or education often does more to reach it. The WTO Secretariat itself points out that "Given the amounts spent on health care in some countries, the question may arise whether alternative approaches aimed at improving the health situation (investments in environmental measures, traffic safety, non-smoking and anti-drug campaigns, etc.) carry higher returns." See WTO Secretariat, op. cit. 77, footnote 4.

114. Sinclair, S., op. cit. 18, p.60.
115. Early Day Motion 260, website: <http://edm.ais.co.uk/>
116. Article IV requires WTO members to facilitate the increasing participation of developing countries by "the liberalization of market access in sectors and modes of supply of export interest to them [developing countries]."
EU Trade Commissioner Pascal Lamy admitted in November 2000 that the EU has "offensive export interests in the field of those services which are regulated as public services. That is an important distinction between GATS and GATT. With GATS, reciprocity is not the same – there is none. If we have a strong interest in the field of health, we're not obliged to make commitments but can take advantage of opening up other markets". Quoted in Caroline Lucas MEP, "GATS-The EU Perspective", speech at WDM GATS seminar, 29 March 2001.
117. Articles XI and XVI state that:
- restrictions must not be applied on transfers and payments for current transactions relating so specific sectoral commitments;
- there must not be any restrictions on capital transactions inconsistent with specific sectoral commitments;
- a country is obliged to allow a cross border movement of capital if it is an essential part of the movement of service covered by specific sectoral commitments.
118. UNISON, *Public Services Manifesto*, London, website: www.unison.org.uk. See also "Stop the GATS Attack, International Statement", website: <http://www.citizen.org/pctrade/GATS/GATSsignon.htm>
119. Hall, D., "The Public Sector Water Undertaking", PSIRU, Greenwich, February 2001. website: www.psiu.org
120. Watkins, K., "Behind Closed Doors: Why the Poor will Suffer if Globalisation is not Controlled", *The Guardian (Society)*, 13 December 2000, p.9.

SUMMARY

Trading Health Care Away?

GATS, Public Services and Privatisation

Last year, the World Trade Organisation (WTO) began talks to expand one of its agreements – the General Agreement on Trade in Services or GATS. Services are now a significant part of the economies of industrialised countries and are governed by complex domestic regulations. These countries are now trying to revise the Agreement to increase international trade in services. If they are successful, GATS could be used to overturn almost any legislation governing services from national to local level.

Particularly under threat from GATS are public services – health care, education, energy, water and sanitation, for instance. All of these are already coming under the control of the commercial sector as a result of privatisation, structural adjustment and reductions in public spending. A revised GATS could give the for-profit sector further access and could make existing privatisations effectively irreversible. Experience in the United States and several Latin American countries, where health services have been run for profit over the past decade or so, suggests that the result will be a decline in accessibility to health care worldwide.

This briefing outlines the growth in services in recent years, the main provisions of GATS and its proposed revisions, and some key corporate aims in extending the Agreement. It details how public services may not in fact be excluded from GATS. It considers what may happen if private companies are enabled to capture the most profitable components of publicly-provided and -funded health care services: a two-tier health system in which a reduced public sector has to cope with the elderly, chronically sick and the poor who most need health care and who can least afford it.

This briefing was compiled by Sarah Sexton, The CornerHouse, drawing on the work and comments of the following to whom immense thanks are due: Meri Koivusalo, GASPP/STAKES; Allyson Pollock, University College London; David Price, University of Northumbria; Clare Joy and Petra Kjell, World Development Movement; Ellen Gould; Mike Rowson, MEDACT; Erik Wessilius, Adam Ma'anit and Olivier Hoedeman, Corporate Observatory Europe; Geof Rayner, UK Public Health Association; David Hall, Public Services International Research Unit; Caroline Lucas MEP; Kasturi Sen, University of Cambridge; Alexander Nunn, University of Manchester; and James Munro, *HealthMatters*.