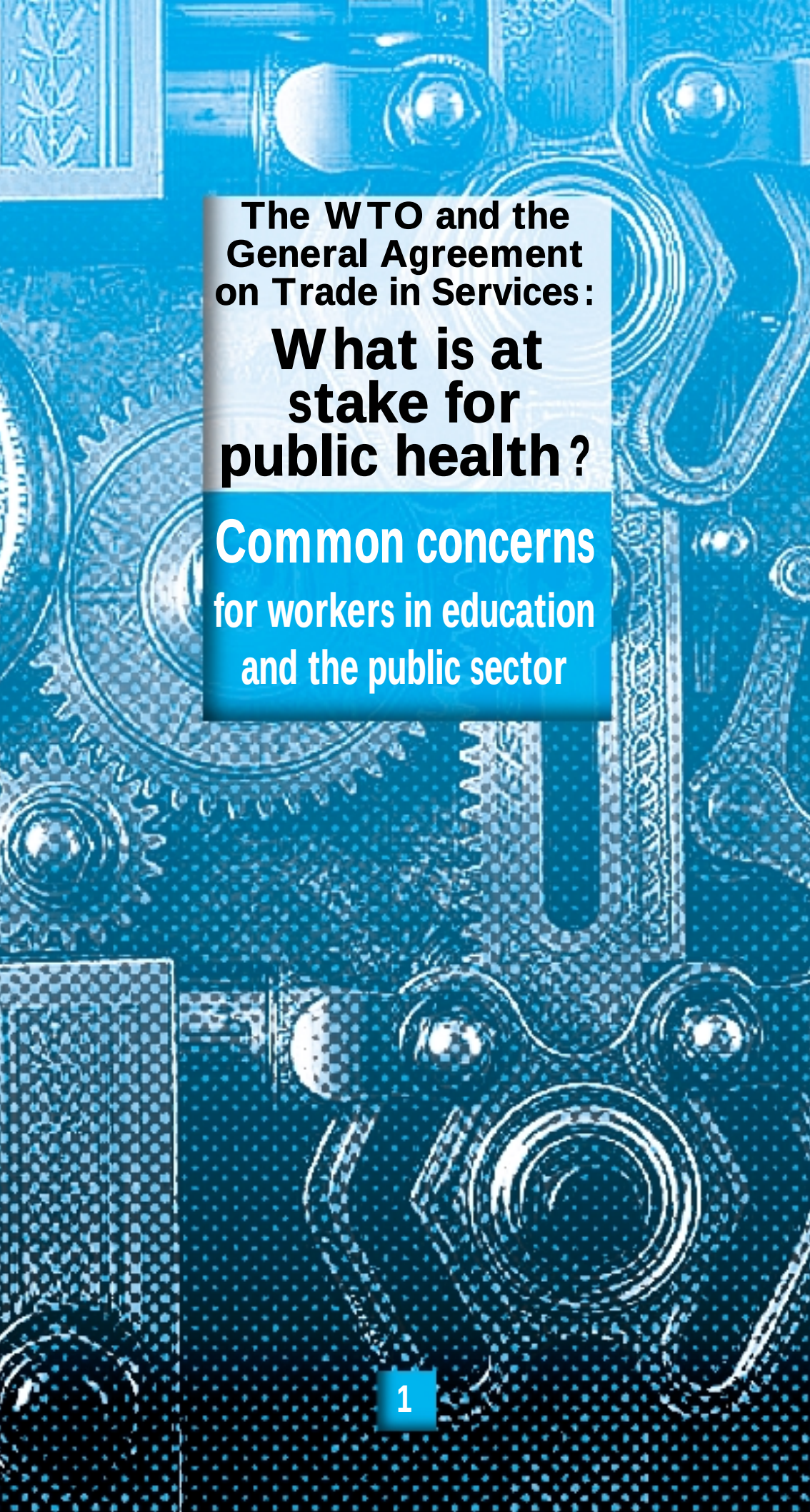

The WTO and the General Agreement on Trade in Services: What is at stake for public health?

Common concerns

for workers in education and the public sector

introduction

Education International (EI) and Public Services International (PSI) have agreed to publish jointly in areas of common concern and we have identified a number of areas where future publications could be developed. PSI is the international federation of public sector trade unions, EI the international federation of workers in education.

This is one in the series of *Common concerns for workers in education and the public sector,* produced jointly by PSI and EI. The papers in this series are meant to serve several purposes: to help trade unionists understand some of the issues; to enable trade union educators to run short sessions on education and public sector issues with their members; to provide material for union leaders writing speeches or informational material for wider audiences; and for distribution to a range of interested people. Further copies can be obtained from:

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At the stage this *Common Concerns* publication was finalised (June 1999), titles in the series included:

1. The WTO and the GATS: What is at stake for public health?
2. The WTO and the Millenium Round: What is at stake for public education?

Introduction

At the Ministerial Conference in Seattle, USA, in November 1999, the World Trade Organization (WTO) will consider how to relaunch negotiations on trade in services in the General Agreement on Trade and Services (GATS). Trade in health services has been discussed since 1994 and there is every indication that in the next year this process will accelerate. The WTO says that countries should reconsider the "*depth and breadth of their commitments*" on health and social services, which are currently "*trailing behind other sectors*". The health industry, already battered by cost control and commercialisation measures, is in for a shake-up.

For these last two sets of reasons, it is very important for health workers and public sector trade unions to understand the issues raised in this booklet and to act on the suggestions for action outlined at the end.

While much in this booklet is aimed at the deadline for the Seattle WTO Ministerial, it is clear that governments' commitments in health services in GATS will continue to develop and therefore monitoring the GATS will be an on-going task for unions.

The stated overriding objective of the WTO is to ensure that international trade flows as "*smoothly, predictably and freely as possible*" (source WTO website June 1999). In so doing, the WTO hopes to "*improve the welfare of the peoples of its member countries*".

However, the objectives of the WTO do not include the promotion of social equity, the protection of national sovereignty nor the improvement of health services and health outcomes[1] for the peoples of its member countries.

The objectives of the WTO do not include the improvement of working conditions for health workers. Nor does the WTO promote better job security and involvement in social partnerships for health workers and the organizations they are part of.

WTO rules and agreements are now sharply focussed on trade in the health sector. The inevitable liberalisation of international trade in health services will bring with it big challenges for health unions. Some of these issues and challenges are outlined in this booklet.

Over the past 20 years, the dominant international agreement in relation to health has been the World Health Organization's (WHO) Health for All by the Year 2000 strategy. This strategy emphasises the importance of health as part of social justice. It promotes a focus on primary health care as a means of securing real improvements especially in poor countries, but also applies to industrialised nations as well.

However the 2000 strategy has been undermined by more selective approaches promoted by organizations which do not have a main function in health policy. The WTO focus on the health industry is part of a trend : increasingly organizations that have not previously been involved in the sector, such as the

1 Health outcomes are the resulting levels of health for individuals and communities which flow from the application of health policies.

World Bank and USAID (source: International Agencies & Health Policies, GASPP[2] 1999) are having more and more influence on it. The direction of that influence is consistent, irrespective of the nature of the institution. The likely end results mean less national control, more targeting of health services, increased denial of universal access and more private sector profit.

This paper, after analysing all of the above issues, proposes a number of implications for trade union action.

This booklet has been produced by Public Services International (PSI) in agreement with Education International (EI). It is being produced in conjunction with EI's production of the pamphlet *The WTO and the Millennium Round – What is at Stake for Public Education?* PSI acknowledges in particular the use of: EI material; unpublished papers by Meri Koivusalo, PhD, of the Globalism and Social Policy Programme (GASPP) 1999; material from the book *International Trade in Health Services*, jointly edited by the United Nations Conference on Trade and Development (UNCTAD) and the World Health Organization (WHO) 1998; and background notes from the WTO Secretariat on *Health and Social Services* 1998.

Written by Dain Bolwell for PSI,
Ferney-Voltaire, France, June 1999.

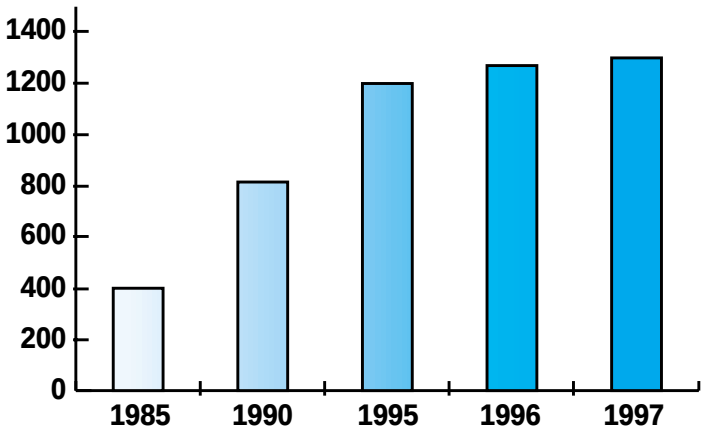
2 GASPP: Globalism and Social Policy Program.

The WTO and the General Agreement on Trade in Services: What is at stake for public health?

From the GATT to the WTO

One of the key dimensions of economic globalisation is no doubt the huge expansion of international trade. The latter has indeed increased tenfold since 1945, particularly as a result of the trend towards trade liberalisation. In 1997, the value of global trade reached US$5.47 trillion. However, economies have developed in such a way that today the provision of non-governmental services amounts to US$1.2 trillion, representing over 60% of the GDP of industrialised countries and 50% of that of developing countries. Although its development began at a later stage, global trade in services has also experienced an unprecedented boom. In 1997, it amounted to US$1.295 trillion, equivalent to about one-fourth of the overall figure for global trade in goods. It is set to grow rapidly, particularly as a result of the emergence of large free-trade areas and the swift development of new communication and information technologies.

Development of international trade in services (in billions of US$)



Source : Compiled on the basis of WTO figures.

For almost fifty years, the task of monitoring and regulating international trade was fulfilled by a permanent negotiating forum. The General Agreement on Tariffs and Trade (GATT), under which member States had the status of contracting parties, had a twofold role. It was both a permanent forum for negotiations and an international agreement, that is, the document laying down the rules for the conduct of international trade.

In 1995, GATT was replaced by the WTO, an international organization which currently groups 135 member countries. Specifically, the WTO is responsible for the implementation of the agreements reached during the last GATT Round (the so-

called Uruguay Round) and signed in Marrakech in April 1994. The Uruguay Round was the most important trade negotiation in the history of humankind. However, whereas the GATT for a long time only governed trade in goods, the WTO Agreements are now also applicable to investments, services and intellectual property rights.

As the sole international body mandated to establish the rules governing trade between countries, the WTO is set to broaden the scope of its action in the future. In this respect, the WTO Agreements play a central role because they are the basic regulatory framework for international trade and the development of trade policies.

The agreements have three main objectives:

- promoting trade liberalisation as much as possible;
- progressively increasing this liberalisation through negotiations; and
- establishing mechanisms for the settlement of disputes.

The General Agreement on Trade in Services (GATS)

International trade in goods is a relatively simple notion since it concerns the exchange of material goods. A given product is transported from one country to another where it is sold. On the other hand, trade in services - because of the latter's non-physical nature - is a much more varied phenomenon and the ways it is described and expressed are more complex. For example, airline companies, telephone companies, banks and accounting firms provide and export their services in very different ways.

The General Agreement on Trade in Services was, in 1994, the first multilateral agreement to be concluded on trade in services as a whole. Because services account for almost two-thirds of the activities carried out in the industrialised economies, it was inevitable that the GATT and its successor, the WTO, should one day tackle this area as one of their major concerns. This is reinforced by increasingly strong pressure from TNCs that wish to sell their products more freely on the world market. TNCs specialising in the provision of services include those in finance, telecommunications, education and transport as well as health. In the first place, the United States took the initiative in the course of the Uruguay Round, to transpose the provisions of the GATT, which already governed trade in goods, by proposing the opening into the area of services as a whole. However, the European Union and a number of developing countries advocated a much more gradual liberalisation process. The result was an agreement more limited in scope.

Nevertheless, the two basic principles underlying the GATT (goods) were preserved and adapted in the GATS (services). The two principles in question are those of *the most favoured nation* and *national treatment*. The first of these requires any GATS member country which grants favourable treatment to another country as regards the import or export of services to grant the same treatment to all other GATS signatories. The *national treatment* principle stipulates that foreign companies which are present in the market of a given country must ben-

efit from treatment at least as favourable as the national companies operating in that same market.

The GATS therefore implies a commitment to liberalise services on an ongoing basis through periodic negotiations. At the global level, it is the first multilateral agreement on investment, since it covers not only cross-border trade, but all possible means of supplying a service. This includes the right to establish a commercial presence on the export market. The service is thus supplied by a foreign company operating in a host country. Hence it is supplied through investments abroad.

Four forms of international trade in health services

According to the WTO there are four forms of international trade in health services:

Mode 1: Cross-border supply

This occurs where the supplier of a medical service in one country makes the service available to people in another. For example, the WHO and WTO point to telemedical services between US companies and several Arab Gulf states, telediagnostic services supplied by Chinese doctors in China to people in several Asian countries, and Mexico's supply of diagnostic services on samples sent from other Central American countries. Cross-border supply is likely to increase significantly with advances in telecommunication and in particular through the Internet.

Mode 2: Consumption abroad

This occurs when patients actually travel from one country to another to obtain treatment. The treatment may be higher quality, faster, cheaperor simply not obtainable in the patient's country. This includes the practise of people from rich countries seeking exotic therapies in poorer countries. India and Cuba are two countries cited by the WTO as having considerable price advantages in common procedures in this category. In some cases, foreign tourists may fall ill and seek treatment while in another country. Foreign tourists – whether there by accident or design - who were treated in the US in 1996 accounted for $872 million in 'exports'. $550 million was imported in converse circumstances.

Mode 3: Commercial presence or "establishment trade"

This means the provision of health services on a commercial basis by foreign-owned health care providers or health TNCs. According to the WTO, US-based companies operating in other countries "exported" $469 million in health services in this mode, while foreign companies operating in the US sold $1.8 billion in services in 1995. There is also evidence of regional networks being built by suppliers in Asia: for example, a Singapore-based group, Parkway, now owns 11 hospitals and most of a dental surgery chain that operates throughout South East Asia.

Mode 4: Provision of health services by foreign people

A fourth mode includes the provision of health services by foreign people ("individual persons") in another country. This

The GATS in a nutshell

The General Agreement on Trade in Services (GATS) is the first ever set of multilateral, legally-enforceable rules covering international trade in services. GATS operates on three levels: the main text containing general principles and obligations; annexes dealing with rules for specific sectors; individual countries' specific commitments to provide access to their markets. GATS also has a fourth element: lists showing where countries are temporarily not applying the «most-favoured-nation» principle of non-discrimination. These commitments - like tariff schedules under GATT - are an integral part of the agreement. So are the temporary withdrawals of most-favoured-nation treatment. Negotiations on commitments in four sectors have taken place after the Uruguay Round. A full new services round will start no later than 2000.

Source : WTO

is, in effect, the movement of people supplying health services, such as doctors and nurses. It includes the temporary employment of health professionals as is common in the Arab Gulf states. However, it is also part of the overall issue of the movement and migration of health professionals. This can impact severely on poor countries with low wages and poor working conditions where such skills are already in short supply. On the other hand it can also bring about relief in countries with insufficient health staff and which are unable or unwilling to supply skills from the domestic labour market. The countries which are the losers of skills are those at the bottom of the wealth scale. Health professionals will go where the money is.

In all such cases one particular thing stands out. There is a lack of hard information or data. The WTO itself refers to the lack of quantitative information several times in its own 1998 Note on Health and Social Services. For example:

- (para. 18) *"evidence suggests that volume is still relatively modest";*
- (para. 21) *"although there are no aggregate estimates available, it appears safe to assume..."* re. consumption of health services abroad (mode 2);
- (para. 24) *"the Secretariat has found quantitative information only for the US..."* re. commercial presence (mode 3).

This lack of firm data is a problem of unknown dimensions. It is probably not safe to assume anything. In the future we may not know how much things have changed, if we do not know today's base-line data.

Commitments already made under GATS

Under WTO rules and agreements, countries make various "commitments" when they sign on to an agreement. In other words, they say they will or will not do specific things (such as allowing foreign doctors to open a clinic) either now or in the future.

When analysing the picture of commitments already made under GATS by WTO member countries, it is important to note that the overriding trend is for a progressive liberalisation of policies affecting trade in that sector. In other words, future negotiations will result in the repeal of policies affecting trade barriers in the services for which the commitments are made. The member countries have signed up for the beginning of such a process. The end is not yet in sight.

A total of 59 countries (nearly half the WTO membership) have included one or more aspects of health services in their GATS schedule of specific commitments (UNCTAD/WHO, 1998).

The tables 1 and 2 at the end of this document give a more specific picture of commitments already made under GATS by member countries:

Table 1 shows the type of services for which commitments have been made by each country to open up access to their markets. Note that the highest number of commitments (76)

is for health insurance. The second highest (49) is for professional medical and dental services. This includes hospital outpatient services according to the WTO (hospital in-patient services are treated separately under "hospital services").

It is not uncommon for poor countries to make a wider range of commitments than rich countries. For example, Sierra Leone has made commitments in all 8 categories, whereas the US has commitments in only two categories. The reason for this is that such countries may wish to attract services in order to fill vacuums or to bolster services which are currently in short supply. A further reason for this is that it may fit in with the structural adjustment programmes imposed by the IMF or the World Bank.

Table 2 shows the number of countries committing to a specific mode of commitment. For each, the three columns add up to the total shown in the 2nd column. For example, 49 countries have committed on cross-border supply (mode 1). Of these, 17 are fully committed, 6 committed with limitations and 26 unbound. A *full commitment* implies an open market and no discrimination against foreign service providers. *Limited commitment* implies that the market in that sector will not become more restrictive in the future. It is a significant step towards opening a market to outside interests. The *unbound* commitments may still allow the introduction of measures to regulate foreign service delivery, but are often unbound for reasons to do with lack of present technical feasibility. They are nevertheless a first step in reducing barriers.

The highest number of limitations are in relation to mode 3 (commercial presence). It is therefore likely that this area will be under the heaviest pressure for change in the next WTO round of negotiations.

A key issue, according to UNCTAD, is the world-wide portability[3] of health insurance because it facilitates the movement of consumers and helps to reduce overall costs. UNCTAD also points to the advantages of regional trade agreements similar to ASEAN, NAFTA, EU and MERCOSUR[4], especially for developing countries. In such ways, trade in health could be more easily integrated and harmonised and gaps in services more easily filled in a regional context.

Pressures on the health sector

Since the Health for All by the Year 2000 strategy was announced by the WHO in 1979, there have been vast changes to the health sector throughout the world. Often the changes were co-incidental to the strategy, linked to it solely through economics and ideology. Everyone working in the industry in the last 20 years will be familiar with some of the developments in health sector policies.

3 An insurance or benefit is "portable" if a consumer or beneficiary can keep the entitlements/coverage as she/he moves from employer to employer and/or from country to country.

4 ASEAN: Association of South East Asian Nations; NAFTA: North American Free Trade Agreement; EU: European Union; MERCOSUR: Common Market for certain Latin American countries.

There is a huge disparity in the actual amount of money spent per person on health services. In poorer countries, average expenditure per person 1990-95 was as low as US$20 whereas rich countries averaged about US$2,400 per person – about 120 times more. According to the WTO, 90% of world health expenditure in the mid 1990's was committed by the 24 OECD countries.

There has been an overall general increase in spending on health–related services. In OECD countries an average of about 8% of GDP was spent on health in 1992, compared with around 5% of GDP in 1970. Poor countries tend to spend less on health (less than 3% of GDP in 1990-95 in Sub-Saharan Africa for example), but spending has also increased there over the last twenty years.

The main factors associated with rising costs are as follows:

- ageing populations, especially in rich countries, contribute to higher costs due to the increased prevalence of conditions needing treatment. People aged over 65 are 4 times as expensive in health costs than are lower age groups;
- new disease epidemics such as HIV / AIDS are increasing and are expensive to treat;
- universal insurance schemes are now more widespread. All OECD countries except the US have universal basic health care cover. As a result, people tend to regard health services as a basic right without reference to costs.
- the prevalence of insurance schemes providing nearly full cover means that there is little incentive for patients to consider the cost of treatment;
- new medical technology is often more expensive than the systems it replaces, yet because it is available people expect to have access to it;
- increased specialisation by some health professionals implies longer training time and higher costs;
- health care planning can be inadequate to deal with changed patterns in demand. As a result health facilities such as hospitals may have excess capacity in some areas and undercapacity in others;
- decisions by doctors may waste resources through over-servicing or inappropriate treatments. This waste may be as high as 30 to 60% of spending according to an OECD 1996 report.

At the same time, revenues available to the public sector have been falling. Some of the factors associated with this are:

- ageing populations in rich countries have resulted in relatively fewer people in the paid workforce, which has reduced taxation revenues;
- in some countries, such as France and Germany, unemployment levels have remained high, which not only reduces tax revenues but also increases the drain on revenue through unemployment insurance payments. In many Asian economies, the 1997 financial crisis severely increased unemployment and cut economic growth;
- there are more opportunities for the rich in many countries to hide their wealth through legal loopholes or overseas and thus avoid personal taxation. TNCs also structure their accounts in such a way as to avoid national taxes;
- there has been global financial pressure for countries to reduce taxation levels to a minimum base so as to attract and retain investment;
- there has been an ideological shift to neo-liberal economics. Resulting budget cuts imply smaller public sectors.

As a result of these factors, there has been an increasing emphasis on measures aimed at increasing efficiency. This means maximising output while minimising inputs. Partly dri-

ven by ideology and partly by pure economic pressures, these measures have included commercialisation, privatisation and limitations on universal access to some services.

The health sector has been subject to the theory of managed competition. This trend has been lead by the OECD and also by the increasingly important actions of the IMF and the World Bank in developing economies. The theory is that the discipline of the market will act to contain cost pressures through competition, while more efficiently delivering services according to consumer demand. The role of the public sector is claimed to be that of only setting the parameters for that competition. Under the new philosophy, commercialised or private providers are to be given rights to operate in the new more open health industry.

At the same time access to some services has been restricted to those who can afford it, while there has been increasing use of co-payment arrangements whereby individuals have to pay directly some of the costs of their health care in an increasingly privatised health sector. This has meant reductions in the size of the public sector health workforce, redundancies and wholesale transfers to the private sector.

This shift to a privatised health service has an impact on trade union strength. In the private sector, unionisation rates are lower. Wages and conditions - especially in relation to casualisation of employment and lack of job security - tend to be worse, especially at the lower skill levels of the workforce.

According to the WTO, the total health expenditure by OECD countries represents US$2,000 billion ($2 trillion) per year. The overall size of the world health industry, by direct extrapolation, is therefore around US$2220 billion per year. However, this figure is probably conservative. The UNCTAD for example, quotes estimates that are 50% higher: US$3 trillion for the OECD countries' expenditure, and therefore US$3,330 billion for the world. This, then, is the potential size of the market under consideration by the WTO.

Issues associated with trade liberalisation in health

Many of the issues associated with trade liberalisation in the health sector are already familiar to unions that have experienced the effects of cost-containment and economic liberalisation programmes over the past decade. Others are more complex and less clear. The overall issue arises from the increasing influence of outside interests on national and international health policy. For unions, the question is how to minimise the adverse effects of trade liberalisation on national working conditions and employment, while at the same time promoting better health outcomes for all. The specific issues include:

Loss of national sovereignty

The WTO takes some pains to point out that agreements reached in negotiation are those agreements voluntarily made by sovereign national governments. Therefore, it asserts, there is no question of the WTO dictating to individual nations. However this is not the whole story. It is possible for nations to enter into trade liberalisation agreements which have unforeseen consequences. Because the whole purpose of the GATS is to promote international trade, it does not focus on other issues such as equity and fairness for consumers of health services, nor on labour considerations of those supplying the services. A recent example of this is an attempt by the Canadian government to promote cheaper medicines by encouraging the prescription of drugs by non-commercial (generic) names, rather than by brand. Under the North American Free Trade Agreement (NAFTA), a non-Canadian pharmaceutical firm suc-

cessfully threatened legal action against Canada for potential loss of market share and profit in relation to its established drug brands. As a result the government backed down and consumers continue to be prescribed more expensive medicines.

Trade more important than health

The role of the WHO in setting health policy has been under threat for some time. Because there is so much money potentially involved, the dominance of trade issues over health issues will probably strengthen. According to GASPP, at the 1986 WHO World Health Assembly there was strong opposition to the notion that the WHO should be involved in efforts to regulate private industry in the health field. Specific issues included baby food products, pharmaceuticals, tobacco and alcohol. In fact the US has withheld its contributions to the WHO budget because it disapproved of WHO policies in favour of breastfeeding as opposed to infant formula. The focus of pharmaceutical policy is now not in relation to health, but rather on industry-related issues such as technical barriers to trade and industry "self-regulation". A recent WHO / UNCTAD book "International Trade in Health Services" paints a rosy picture of current and potential trade in health services, yet devotes only a few passing references to how such trade might improve overall health outcomes. The European Union made a decision in 1998 that no priority should be given to health over intellectual property considerations, in particular where there is no evidence of conflict. To the EU, trade is certainly more important than health.

Extended private influence on international health policies

The extent of privatisation is now being determined by those organizations that have a direct profit interest in the health outcomes. The lack of funding for UN agencies, such as the WHO in the past decade or so, has meant that there is a real threat to their integrity. In 1998 the WHO Executive Board proposed a resolution promoting public health over commercial interests. As a result of industry lobbying, the resolution was rejected by the World Health Assembly and returned to the Executive Board. The WHO has recently stated that it wants to enter into more co-operative arrangements with industry in the health sector, especially in research and development programmes. Large TNCs such as Nestlé already send more delegates to international WHO forums on standards than most governments. According to an NGO study, 81 % of non-government delegations in committee meetings setting world food standards between 1989-91 were industry representatives. Pfizer, the pharmaceutical TNC, has more staff in its marketing department than there are in the whole of the WHO (Financial Times 1997).

Extended privatisation

Increased privatisation is a logical result of the increasing influence of private industry on international health policy. Whilst significant privatisation and commercialisation programmes have already been carried out in most countries in the health industry, this is only the beginning. The very size of the industry makes it an attractive target for profit. Whilst the private sector has direct influence on this, there is also indirect

pressure from international financial institutions to privatise and / or commercialise the health industry, especially in countries dependent on their loans. The WTO itself acknowledges the dangers in this: *"… private health insurers competing for members may engage in some form of "cream skimming"* (see separate point below) *… 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…"* (WTO Secretariat, 18 September 1998). According to the New York Times Service (17 June 1999), there has been a dramatic increase in privatised domestic and US (foreign) involvement in Latin American health insurance and managed care arrangements. TNCs such as Aetna International, Cigna International and the American International Group now have over 5 million members in 7 Latin American countries.

Increased targeting of health services

There are two sorts of health service targeting. One is the targeting driven by the need to maximise effectiveness and efficiency. For example services may be set up to deliver preventative services to groups of people known to be at high risk of particular diseases. This can be considerably more effective and efficient than delivering preventative services to an entire population, many of whom may not be at risk. The other sort of targeting is driven by the decline of universal public health care; that is, the provision of free or low price services is increasingly restricted to a narrow group of people defined by their relative poverty. In this sort of targeting, the majority of the population is not eligible for free or low price service but instead must pay more of the total cost. The cost of course will increasingly include the profit margin of the private supplier, as privatisation is extended under trade liberalisation agreements. For the affluent, services are often better than those provided by a universal system, which only decreases their incentives to support continued funding for a public health service.

Increased use of telemedicine

Just as globalisation itself is not possible without the rapid changes in telecommunications technology, the advance of cross-border trade in the health sector is also dependent on this technology. Health services are particularly information intensive. Many health issues – epidemics being the most obvious – do not respect national political boundaries. Already countries such as the US, Australia, Norway, Japan and Canada are making extensive use of telecommunications for medical education, diagnosis and treatment. Japan for example already has telemedical links between its hospitals and health care sites in Cambodia, Fiji, Papua New Guinea and Thailand. There are routine telemedical links between hospitals in the US and Saudi Arabia, through a purely commercial provider, WorldCare. The UNCTAD describes this area of trade as *"poised to take off"* as soon as governance-related issues are resolved (p.110, International Trade in Health Services, UNCTAD / WHO 1998). The particular issues associated with this change include: the elimination of the traditional face-to-face doctor-patient relationship; the ethical-legal consideration of services operating outside of national boundaries; and especially equity of access for people without access to telecommunications or without insurance to pay for the increasingly commercialised services. In addition, as telemedicine becomes more extensive, the nature

of the work and hence the labour intensity of health services will change. If actual physical presence is not necessary, then many health support occupations, e.g. cleaning, catering, clerical and administrative functions, are no longer necessary or can be minimised. As telemedicine alleviates skill shortages, it will become a factor for employers to pressure employees to accept lower wages.

Reduction of health quality standards

This is a highly contentious issue. The fourth mode of commitments - especially temporary employment in foreign countries - is particularly affected, as well as actual permanent migration of health professionals. Liberalisation in these areas will require harmonisation of standards of qualifications on a global level. In harmonisation exercises there is an automatic tendency to align qualification levels with minimum standards applying to the widest range of countries. To align levels with maximum standards invites difficulties and objections from the bulk of countries which do not meet those standards. This means that there may be a new downwards levelling force in many countries which now enjoy high standards of medical training and qualification. Further, in cases of consumption abroad (mode 2), there is a tendency for poorer countries to use their comparative advantage in price and sometimes language to attract consumers from richer countries. In so doing they risk denying access to local consumers. This has been booming for some time in Northern Mexico where health services are increasingly accessed by Hispanic US citizens seeking a cheaper, Spanish language service. If, as is likely, the health professionals most engaged in this profitable trade are the better qualified ones, it follows that there must be a reduction of standards applying to local patients. It can be argued that telecommunications, particularly as far as medical education is concerned, can mean a counter trend of better access to expertise and information. However the points remain that harmonisation of qualification standards to meet freer trade requirements and increasing consumption abroad may well result in both a levelling and lessening of available skills and hence of quality of service.

Loss of job security

Health workers around the world are especially aware of this result of cost-containment and economic ideology in the health sector. As market forces rather than public policy increasingly dominate the health sector, there are more redundancies, more casual jobs which were once permanent, more contracting out of parts of services, and more labour cost reduction by firms in the market. Whilst this tends to more severely affect workers at lower skill levels where there is a greater labour supply, it also affects health professionals, especially nurses working in institutions such as private hospitals and aged care facilities.

Reduction of democratic decision-making

The commitments made by the 135 member countries of the WTO are in effect commitments that bind both present and future national governments. They also undermine democratically elected sub-national levels of government. As such they can significantly reduce the policy options available to gov-

ernments now and in the future. The commitments made to date already mean that the countries concerned will go further in the direction of liberalisation and opening their markets to foreign competition in the 4 modes described. The fact that the commitments have been entered into at an international forum such as the WTO and yet circumscribe future national policies means that the decision-making is remote from the constituency, both geographically and temporally. National policies are as a result less transparent and less subject to democratic scrutiny. According to GASPP, there is now a lack of awareness of trade-related issues within the health sector. It is critical that national level commitments to social equity in health do not become interpreted as soft, compared to the hard rules of international trade commitments.

Reduction of working conditions

Except for the few highly skilled, highly specialised health professionals, experience around the world so far suggests that working conditions for most other people employed in the health industry will decline as a result of trade liberalisation. There are several reasons for this. One factor is that a big motivation for the US in driving trade liberalisation in health is the incentive to cut costs because its health spending is now the highest in the world (13.5% of GDP versus around 8% of GDP for other OECD countries, according to the World Bank). According to the WTO and the OECD, much of the reason for this is "*unusually high input prices*" (WTO Secretariat 1998). Much of the higher cost in the US system is a result of the much higher administrative burden resulting from the competing private agencies - although some of the US spending dilemma results from relatively high labour costs. Another factor driving liberalisation is that freer trade will allow easier access for health workers from cheaper countries to work in higher paying countries and will more easily overcome skill shortages. While this is generally desirable, an increased labour supply in the richer countries must slow improvements in pay and working conditions there, while reduced supply in the losing countries risks more overwork and higher ratios of patients to staff (see the separate point on mobility below). A third factor is that privatisation brings with it a view of labour as a cost, rather than an investment in skills. Labour costs – especially of those most vulnerable – will be reduced by employing fewer people and by increased casualisation. In both ways working conditions are made more difficult. Lastly, in consumption abroad, one significant competitive advantage that poor countries have is cost of health services, because working conditions are poorer. The higher the degree of such consumption by patients from wealthier nations, the greater are downward pressures on conditions for employees who do not migrate.

Access disparity

TNCs are particularly interested in countries with an affluent elite willing to pay for private health services. There has already been considerable expansion in private health care in Latin America as noted by the Economist and the New York Times Service (1999). GASPP quotes heavy criticism over the marketing of managed care in Latin America and of the support for it by the World Bank and IMF. The continuing encroachment of TNCs in such areas can only increase disparity of access to health services between population segments. The

elite will be able to access private TNC-controlled care; the rest will have to make do with the shrinking public system. In rural areas the disparity is worsened: private companies tend not to operate there at all. They are content to have creamed off the low-risk elite in the cities, leaving a degraded public system to cope with the rest.

Increased mobility of health professionals

As qualification standards are harmonised and immigration restrictions are relaxed to promote trade liberalisation, those health professionals with skills in demand are likely to increase their movement to countries offering better remuneration and conditions. There is already considerable mobility amongst health professionals, especially from developing to industrialised countries. India for example exports large numbers of doctors seeking better remuneration. Nurses are highly mobile for both temporary (contract) jobs and for more permanent positions involving actual immigration. A significant example of this is Filipino nurses migrating to the US. Regional trade agreements are probably the next step in aligning competency standards amongst similar countries to enable improved mobility. Increased mobility can have negative consequences for developing countries already subject to a "skill drain". In Jamaica, for example, over 50% of nursing positions are unfilled as a result of migration of its nurses to North America (WTO 1995). The resulting oversupply of laobur can also act to suppress improvements to pay and conditions of work in receiving countries.

"Cream skimming"

This is a general phenomenon of privatisation and one that has been encouraged by the World Bank. Private insurance companies, including several US-based TNCs, are now operating in Latin America. The Director of the Harvard School of Public Health, Professor William Hsiao, has said of this that *"the insurance companies take the cream off the top… by selecting the best risks… predominantly young and healthy members…. they do not operate in the countryside where health services have always been sparse…"* (New York Times Service, 17 June 1999). The purpose of this behaviour is of course to maximise profits. Its effect, however, is to put an increasing and disproportionate cost burden on the public health system which is left with those people who cannot afford private care, either because of poverty, chronic illness or both. The overburdened public system then becomes a further incentive for middle class people to seek private access, and access disparity is worsened.

All of these issues are closely inter-related. Their common thread is trade liberalisation. Many of them are not mentioned at all by the WTO paper on health and social services or, if mentioned, are covered in a cursory manner. They must be addressed in future trade negotiations at the WTO in the interests of all who are involved in the health sector, in sending an receiving countries alike.

Recommended Actions for Unions

The above issues explain the need for urgent action by trade unions not only to impact on the negotiations at the WTO Ministerial Conference in November 1999, but also to keep up constant pressure on governments.

- Support the ICFTU / ITS position on the WTO Seattle Ministerial Conference. A bargaining position on the WTO negotiations has already been developed by the International Confederation of Free Trade Unions (ICFTU) in co-operation with International Trade Secretariats (ITSs). It includes the necessity of enforcing core labour standards through the WTO and the International Labour Organization (ILO). The ICFTU web-page *Jobs and Justice* has an on-line version of the position paper and campaign details (www.icftu.org).
- Find out about the timing of national and international meetings leading up to the WTO Ministerial Conference and the specific commitments made and proposed by your country to the WTO. Trade and Health Ministries will have the information available but this and much other WTO information can also be found on the WTO web-site (www.wto.org) and on the site of the International Centre for Trade and Sustainable Development, an NGO which assists other NGOs working on WTO issues (www.ictsd.org).
- Try to get at least one trade union representative onto your government's national delegation to the WTO – something which has been possible for several countries at the last two WTO Ministerial Conferences.
- Lobby your national government - especially the ministers for trade and health.
- Network with non-government organizations (NGOs) operating in the health sector which have a common interest with trade unions.
- Raise the issues with national trade union centres for co-ordination and representation.
- Insist on adherence to ILO core labour standards in your country.
- In the longer term, enter social dialogue on the issues with your government and organizations representing significant community sectors in your country.
- Raise these matters as public issues as part of a 'Quality Care' campaign in your country.

This is a supplement to the
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the WTO and Education.

Table 1:

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

Members	PROFESSIONAL SERVICES			HEALTH-RELATED AND SOCIAL SERVICES				
	Medical and dental services	Veterinary services	Nurses, midwives, etc.	Hospital services	Other human health services	Social services	Other	Health insurance
Antigua and Barbuda	●							
Argentina								●
Aruba								●
Australia	●	●			●			●
Austria	●	●	●	●	●	●		
Bahrain								●
Barbados	●							
Belize	●				●			
Bolivia				●				●
Botswana	●	●	●					
Brazil								●
Brunei Darussalam	●							●
Bulgaria	●	●				●		
Burundi	●	●		●	●			
Canada								●
Chile								●
Colombia								●
Congo RP	●	●						
Costa Rica	●			●				
Cuba								●
Cyprus								●
Czech Republic	●	●						
Dominican Republic	●			●	●	●		●
Ecuador				●				●
Egypt								●
EC (12)	●	●	●	●		●		●
Finland		●	●					
Gabon								●
Gambia	●	●	●	●	●	●		●
Ghana								●
Guinea		●					●	
Guyana	●							●
Haiti		●						
Honduras								●
Hong Kong, China								●
Hungary	●			●	●	●	●	●
Iceland		●						●
India				●				
Indonesia								●
Israel								●
Jamaica	●		●	●				●
Japan				●				●
Kenya								●
Korea, Rep. of								●
Kuwait				●	●	●		

Members	PROFESSIONAL SERVICES			HEALTH-RELATED AND SOCIAL SERVICES				
	Medical and dental services	Veterinary services	Nurses, midwives, etc.	Hospital services	Other human health services	Social services	Other	Health insurance
Lesotho	●	●	●					●
Liechtenstein								●
Macau								●
Malawi	●		●	●	●			
Malaysia	●			●				●
Malta								●
Mauritius								●
Mexico	●		●	●	●			●
Morocco								●
New Zealand		●						●
Nicaragua								●
Nigeria								●
Norway	●	●	●					●
Pakistan	●			●				●
Panama				●				●
Paraguay								●
Peru								●
Philippines								●
Poland	●	●	●	●				●
Qatar	●	●						●
Romania								●
Rwanda	●							
Saint Lucia				●				
Senegal	●							●
St Vincent and the Grenadines				●				
Sierra Leone	●	●	●	●	●	●	●	●
Singapore	●	●						●
Slovak Republic	●	●						●
Slovenia	●			●	●			●
Solomon Is-lands								●
South Africa	●	●	●					●
Sri Lanka								●
Swaziland	●			●				
Sweden	●	●	●					●
Switzerland	●	●						●
Thailand								●
Trinidad and Tobago	●	●		●				
Tunisia								●
Turkey				●				●
United Arab Emirates		●						
USA				●				●
Venezuela								●
Zambia	●		●	●	●			
TOTAL	49	37	26	39	13	19	3	76

Note: EU Member States are counted individually.

Source: WTO Secretariat.

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

Sector	No. Members (commitment for Modes 1-3)[a]		Cross border supply (Mode 1)			Consumption abroad (Mode 2)			Commercial presence (Mode 3)		
			Full[a]	Limited	Unbound	Full[a]	Limited	Unbound	Full[a]	Limited	Unbound
Medical and dental services	49	(12)b	17	6	26	38	7	4	19	24	6
Veterinary services	37	(10)c	17	2	18	33	1	3	19	14	4
Midwives, nurses, etc.	26	(4)d	6	4	16	21	5	0	10	16	0
Other (incl. medical services)	3	(1)e	2	1	0	2	1	0	1	2	0
Hospital services	39	(9)f	11	1	27	31	5	3	18	17	4
Other human health services	13	(6)g	6	1	6	6	5	2	8	4	1
Social services	19	(2)h	3	0	16	4	13	2	5	13	1
Other health and social services	3	(2)i	2	1	0	2	1	0	2	1	0

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

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

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

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

e Iceland.

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

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

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

i Hungary, Sierra Leone.

Source: WTO Secretariat.

Notes