Commodification of healthcare in transnational contexts: The EU and the WTO compared

Paper presented at "The Social Embeddedness of Transnational Markets"
Joint Conference of CRC 597 and RECON, Bremen, 5-7 February 2009

Markus Krajewski[1]

I. Introduction

Debates and analyses of the social embeddedness of transnational markets are usually based on the observation that the social regulation of markets, a function traditionally performed by the nation state, is increasingly difficult to maintain once markets are liberalized at a transnational level. The tensions between opening national markets to transnational liberalisation processes and efforts to re-embed these markets at the transnational level are particularly apparent in the field of labour and environmental protection. However, the story about dis-embedding and re-embedding markets can also be told with regard to services as the *Laval*, *Viking* and *Rüffert* cases of the ECJ have aptly demonstrated.[2]

The present paper concerns itself with a different situation, which also relates to a movement of opening markets and efforts of re-embedding them, but which adds a layer of complexity to the problem. It studies the transformation of activities which used to be removed from market processes at the national level, in particular public services. These activities had to be turned into marketable products before they could be liberalized. The commodification of these activities was a necessary precondition of their liberalisation and globalisation. There are therefore parallels to the commodification of labour, which *Polanyi* considered as a condition of the development of modern economy. However, the paper does not try to fully apply *Polanyian* theory to the case of healthcare. The author will also refrain from "ripping the most useful parts" from *Polanyi* and transplant them into another theoretical approach.[3] Instead,

[1] University of Bremen, Collaborative Research Center 597, Markus.Krajewski@sfb597.uni-bremen.de. This is a very first draft. Comments and corrections are welcome, dissemination without the authors' permission is not.
[2] Cases C-341/05, *Laval un Partneri*; C-438/05, *International Transport Workers Federation/Viking*; C-364/06, *Rüffert*.
[3] M. Burawoy as quoted in F. Block, Towards a New Understanding of Economic Modernity, in: C. Joerges/B. Stråth und p. Wagner (eds), The Economy as Polity: The Political Constitution of Contemporary Capitalism, 2005, p. 3.

this paper will simply use terminology developed in the *Polanyian* context in order to analyse the transformation of healthcare in transnational structures. In particular, the paper finds the notion of commodification a useful approach to understand the changes that are associated with the liberalisation of healthcare in the EC and WTO policies and the introduction of the "market logic" in this sector. *Polanyi* himself was mainly concerned with commodification of what he called fictitious commodities: Land, labour, money.[4] Post-*Polanyian* scholars have added other fictitious commodities to that list, most prominently knowledge. However, it has also been argued that healthcare is a fictitious commodity.[5] This coincides with popular connotations that "Healthcare is not a commodity". Without being able to develop this argument further, it seems that the problems arising with the commodification and embeddedness of healthcare deserve special attention.

The paper has three main sections: In section II, the paper suggests the conceptual framework for analysing public services in the context of the social embeddedness of transnational markets. It tries to explain the first step of the transformation of public services as a process of commodification. A closer look at commodification shows that three distinct types of commodification can be distinguished: "Rhetorical" or "ideological commodification" takes place when certain activities, institutions and social relationships are described and labelled in commercial terms. This level implies no actual changes but prepares the ground for the ensuing stages of the commodification process by altering the public discourse through the introduction of a new ideology. "Institutional" or "legal commodification" implies changes in the institutional and legal regimes, which will enable commercial and market-based relationships. However, whether consumers and producers take advantage of these changes by creating actual markets relates to "substantive commodification", i.e. the actual establishment of markets as systems of voluntary exchanges of products. Only this form of commodification leads to processes of dis-embedding. Hence, efforts of re-embedding markets will only be attempted once this stage has been reached. Sections III and IV of the paper will apply this approach to the legal treatment of healthcare in Europe and the WTO respectively. They will analyse the extend of healthcare commodification at each of three levels. This should not only shed more light on the relative importance of developments at the European and global level. It should also enable us to explain why we have so far seen little efforts of re-embedding

[4] K. Polanyi, The Great Transformation, 2001 edition, p. 71 et seq.
[5] M. Macintosh, Commercialisation, inequality and the limits to transition in healthcare: a Polanyian framework for policy analysis, 18 Journal of International Development, p. 393 – 406.

healthcare in these sectors. In particular, it will be argued that both regimes have so far largely contributed to institutional or legal commodification, while the extent of substantive commodification has been limited. Future research (and political attention) should concentrate on the emergence of substantive commodification of healthcare in Europe and on a global level. The main questions in this context will concern the conditions of substantive commodification.

II. Another "Great Transformation": The liberalisation of public services in Europe

Since the late 1980s, the regimes of providing public services, such as telecommunications, postal services, energy and water supply, transportation, health and social services in Europe have been fundamentally transformed. Until then many of these services were provided by institutions of the state on the basis of a public monopoly. They were hence on equal footing with other state activities such as education, providing (internal and external) security and administering justice. However, nowadays, these services are provided by private actors on liberalised markets. They are now on equal footing with professional, business and construction services, which have always been provided on a market.

1. The commodification of governmental activities

The transformation of public services has been analysed extensively in social, economic and legal sciences and is usually described in terms of liberalisation and privatisation.[6] Liberalisation means the reduction of measures restricting economic activities in order to create (more) competition. Privatisation refers either to the change of the legal form from a public to a private law organisation (formal privatisation) or to the transfer of ownership from the public purse to private individuals or companies which involves the transfer of the activity from the public to the private domain (material privatisation). It is submitted that these two concepts do not fully describe the transformation of public services. In particular, I argue that liberalisation usually presupposes an existing market, even if that market is dominated by a monopoly. However, the situation of many public services in the 1980s was different.

[6] For traditional legal perspectives see *Burgi* (1998), *Kämmerer* (2001) and *Weiss* (2001). A different approach is taken by *Franzius* (2009). For a critical social sciences perspective see *Bieling/Deckwirth/Schmalz* (2009).

If we understand a market as an institution which allows for the free exchange of goods and services through voluntary arrangements[7] it is clear that there was no market for many public services in the in the mid 1980s. Consider telecommunication services: The traditional model of providing these services in Europe was the so-called PTT model. It meant the provision of telecommunication services through a public institution – often an entity of the government – on the basis of a public monopoly. Consumers had no choice regarding the provider of the service. The price was not based on bargaining, but was determined by the government directly. The same is still true regarding the state's activities to administer justice: Claimants cannot choose the court where they file their claim and court fees are not determined on the basis of demand and supply. We can therefore speak of non-market goods and services. The consumption of these goods and services does not take place on a market.[8] In order to "liberalise" a "non-market", the respective good or activity must first be transformed into a tradable commodity. The fundamental question therefore is: How are governmental activities transformed into marketable services?

For the provision of physical goods, this does not seem to be too difficult from a conceptual perspective. The exchange of goods is more easily understood in market terms. Even if there is a public monopoly for the distribution of certain goods, the distribution of these goods resembles the exchange of goods on a market to a greater extent that the provision of a service through a public monopoly. This can be demonstrated by looking at the example the creation of a market for telecommunications terminal equipment through the EC terminal equipment directive of 1988. This directive required the abolition of all exclusive rights regarding the importation, marketing, connection, bringing into service of telecommunications terminal equipment and/or maintenance of such equipment.[9] When France challenged the directive, the ECJ pointed to the fact that the "terminals sector is characterized by the diversity and technical nature of the products concerned and by the ensuing constraints. In those circumstances there is no certainty that the holder of the monopoly can offer the entire range of models available on the market, inform customers about the state and operation of all the terminals and guarantee their quality."[10] This indicates that the distribution of terminal equipment was already considered a market activity. In fact, if different products exist and

[7] P. Aspers/ J. Beckert, Märkte, in: A. Maurer (Hrsg.), Handbuch der Wirtschaftssoziologie, 2008, 225-246.
[8] Note that the European Commission distinguishes between non-economic and economic services of general interest and defines the former ones as "non-market services", Green Book on Services of General Interest, COM(2003) 270 final, para. 16.
[9] Directive 88/301/EEC of 16 May 1988 on competition in the markets in telecommunications terminal equipment (OJ 1988 L 131, p. 73).
[10] ECJ Case C-202/88, *France/Commission*, [1991] ECR I-1223, para. 35.

there is a general impression that a wider choice would be beneficial for the user, the conceptualisation of the distribution of a good as a market activity is not that surprising.

The case for services is different: In order to turn governmental activities into services, a reconceptualisation of these activities as economic activities must take place, which may involve greater changes of perception than in the case of goods. In a legal approach to the question, the problem associated with this change, is often hidden. For European law, an activity is considered a service (or an economic activity) if there is an element of remuneration (Article 50 EC)[11] or at least if the activity is based on a fee.[12] If the service is predominantly paid for on the basis of general taxes, it is not considered a service.[13] However, this concept is in itself not able to produce meaningful distinctions as many activities of government require the payment of a fee. The commodification of an activity is hence more than simply turning it from a free to a fee-based one. Instead, the commodification of an activity requires a fundamental change in the ideas underlying that activity, its legal and institutional framework and the actual modalities of its production and consumption.

2. Ideology, institutions, substance

It is argued that the process of reconceptualising activities in this respect can take three steps which I would like to introduce as three types or forms of commodification: Ideological or rhetorical commodification, institutional or legal commodification and substantive commodification. "Rhetorical" or "ideological commodification" takes places when certain activities, institutions and social relationships are described and labelled in commercial terms. The commodification is hence only rhetoric. If social workers become "case managers" and people requiring social help become "clients", this implies predominantly a change in the perception of the activity, not necessarily in the activity itself. There can be many reasons for the first emergence of rhetorical commodification. It can be a deliberate choice of policy-makers to create a new context and framework. Often, this form of commodification is dismissed as "window dressing". The argument of this paper is, however, that ideological commodification may prepare the ground for the ensuing stages of the commodification process by altering the public discourse through the introduction of new ideas and concepts.

[11] On the question of remuneration in the context of health services, see below III. 2.
[12] ECJ, Case 41/83, *Italy/Commission*, [1985] ECT 873, para 18.
[13] ECJ, *Humbel.*

At the second level we can observe changes in the institutional and legal regimes, which enable commercial and market-based relationships. At a very basic level this implies the abolition of mandatory contractual relationships. Once the recipients of a service are only allowed to use the service of more than one service supplier or if the service supplier is no longer required to enter into contractual relationships with all potential service recipients, there will be choice and hence a potential for competition. With regard to public services, the question of financial support or use of public funds is often a crucial question. The introduction of vouchers for day care centres for children would be an example. Parents are no longer restricted to the local day care centre, but can choose from different centres and service suppliers. There is hence a possibility to enter into voluntary arrangements. Market-like relationships become possible. However, there are a number of factors which influence whether consumers and producers take advantage of these changes in the legal framework. It may thus very well be that the legal and institutional framework allows for exchanges on the market, but reality is different. If the behaviour of service producers and service recipients remains unchanged, there are no dis-embedded markets. Questions of re-embedding them do not arise.

I would like to call the actual establishment of markets as systems of voluntary exchanges of products "substantive commodification" and treat this as a distinct, third form of commodification. Substantive commodification takes place when consumers and service suppliers are not only able to choose, but exercise this choice to a considerable extent creating opportunities for competition on markets. The reason for this distinction has to do with the idea of re-embedding markets. Neither rhetorical nor institutional commodification actually create a market which requires embeddedness in form of social regulation. We should therefore only expect attempts to re-embed markets through social regulation once substantive commodification has been reached.

The three forms of commodification introduced here should be understood as "ideal types" (*Idealtypen*). In reality, a transformation process may not involve all forms in the same way. In some cases, rhetorical commodification may be less important than the changes in the legal system. Sometimes, the changes in the legal system coincide with the substantive commodification. All three forms may also overlap. There may also be a sequence: In some cases rhetorical commodification may lead to the institutional commodification and subsequently to substantive commodification of the same activity. However, all three levels of

commodification may also occur in different areas and at different points in time. It may nevertheless useful to distinguish these three forms for analytical clarity.

III. The commodification of healthcare in the EU

Based on the three notions of commodification introduced above, the process of commodification of healthcare in the EU can be described as follows.

1. Words and ideas

Rhetorical or ideological commodification of healthcare in Europe began at the national level. A prime example was the creation of the so-called "internal market" in the British National Health Service (NHS) in 1991. The NHS is a universal and comprehensive national health service, funded through general taxes and providing services for free at the point of delivery.[14] Originally the NHS was centrally managed and planned under the authority of the Department of Health. After the government of Margaret Thatcher came to power in 1979, a number of reforms of the NHS were introduced. One of the more important ones, concerns the "internal market". This reform introduced a distinction between "purchasers" and "providers" (or sellers).[15] Hospitals, ambulances, community health centres were turned into semi-independent trusts and were required to act like businesses.[16] The health authorities had to "purchase" health services from these trusts. The "internal market" was, however, not a market in the terms used above. In particular, the different NHS entities were still required to buy from institutions within the NHS system. It was therefore predominantly an instrument aimed at changing the decision-making and management processes in the individual institutions.

Another example of rhetorical commodification are the various attempts to introduce elements of "competition" in the German public health system, which covers about 90% of the population and is based on the mandatory membership of the majority of the population in a public sickness fund (*Krankenkasse*). Since 1996, individuals can choose which sickness fund they want to join. Since the membership fees of the sickness funds may differ, it is hoped that the freedom of choice leads to more efficiency. However, the effects of this competition are

[14] A. Talbot-Smith/A. M. Pollock, The New NHS Guide, 2006, p. 2.
[15] I. Holliday, The NHS Transformed, 1995.
[16] A. Talbot-Smith/A. M. Pollock, The New NHS Guide, 2006, p. 6.

reduced since all sickness funds participate in a fund which equalises losses and benefits within the system. Furthermore, all sickness funds provide the same statutory services and may only offer very few additional services. In light of these characteristics of the German public sickness funds, the ECJ decided that they were not undertakings in the meaning of Article 81 and 82 EC.[17]

Defining these developments as "rhetorical commodification" does not mean that they had no impact on the system. However, it is argued that these changes and the terminology used to introduce and implement them did not lead to a full commodification of health services. The creation of an internal market or the introduction of competition into public health systems aim predominantly at a change of the decision-making process and management structures within these systems. As the ECJ correctly observed in the *AOK Bundesverband* case: "[T]he legislature introduced an element of competition with regard to contributions *[to the sickness funds, MK]* in order to encourage the sickness funds to operate in accordance with principles of sound management, that is to say in the most effective and least costly manner possible, in the interests of the proper functioning of the German social security system." Competition is therefore a steering instrument of government not a method to turn health service into an activity which is fully tradable on a market. The fact that almost everyone is legally required to enter into a contract with a sickness fund and that the contents of such a contract are determined by the legislature suggest that this exchange does not take place on a market as defined above.

It is worth pointing out that the above-mentioned examples of "rhetorical commodification" did not originate at the European level. Instead they were developed within a national system. More importantly, this commodification concerned the relationship between the organisations of healthcare (health authorities, public sickness funds). It did not concern the relationship between the patient/insured person and the organisations of healthcare. This relationship became however subject to "institutional commodification" through developments in EC law.

2. Free movement of healthcare services in EC law

The creation of legal framework for a transnational market for healthcare is still in its early days. However, the first steps, in particular the legal conceptualisation of the transnational

[17] ECJ, Case C-280/00, *Altmark Trans.*

provision of healthcare as the provision of services under EC law have been taken. The ECJ's jurisprudence on patient mobility within Europe was the starting point. For the first time in *Kohll* and *Decker*, the Court stated that an EU citizen may claim reimbursement for medical treatment abroad from his or her national health service provider even if there was no prior authorization to obtain these service abroad.[18] In subsequent cases the ECJ upheld this view.[19] The basic line of reasoning of the court was as follows:

(1) Medical services are services in the meaning of Art. 49 ECT, because they are provided for remuneration, which is the key element of the definition of a service under the ECT. The Court neither accepted the arguments of some Member states that health services are special and should not be subject to the freedom to provide services nor the view that health services in systems based on a benefit-in-kind scheme were not provided for remuneration. The Court was simply of the view that since the patient would normally pay for the health service abroad and then claim reimbursement, the service was provided for remuneration.

(2) Since medical treatment in another Member state falls under the provisions of the ECT's chapter on services, the requirement to ask for prior authorization or the refusal to compensate constitutes a restriction on the freedom to receive services.

(3) This restriction can only be justified on the basis of overriding reasons. In particular, the ECJ accepted that such restrictions could be necessary to ensure sufficient and permanent access to a balanced range of high-quality hospital treatment and to control costs and to prevent, as far as possible, any wastage of financial, technical and human resources. However, the Court only accepted this possibility for hospital services. The judges saw no reason to apply this line of thinking to non-hospital services as well. As a consequence, patients can now choose a doctor abroad for any necessary medical treatment and claim reimbursement for these costs (excluding travelling etc.) if the service was medically necessary and if the costs of such a service would have also been reimbursed (or covered) by the domestic health system if the service would have been supplied at home.

The reasoning of the ECJ and the implication of its jurisprudence on the national health systems of the Member States have been extensively analysed and critically assessed in the

[18] Case C-158/96, *Kohll*.
[19] See in particular Cases C-157/99, *Smits and Peerbooms;* C-385/99, *Müller-Fauré and van Riet* and C-372/04, *Watts.*

literature.[20] For the purposes of the present paper, two aspects of the ECJ's approach are important. First, it should be noted that the Court's approach to the notion of service is based on a formalistic and individualistic perspective. The court simply asks whether there was an activity exercised on the basis of some form of remuneration. This approach does not take the context of this activity into account. From a pure legal perspective such an approach seems acceptable. However, it is submitted that such a perspective disregards the complexities of healthcare systems in general.

Second, and more importantly, the ECJ's jurisprudence created the legal framework for actual market exchanges in an area where such exchanges did not exist beforehand. This becomes apparent when on considers a patient in a country with a health system based on the provision of benefits-in-kind, such as the mandatory public health insurance scheme in Germany. A patient insured under the scheme receives health services (and medicines) from his or her public sickness fund. Even though the relationship between the patient and the healthcare provider (doctor or hospital) is based on a private law contract, there is no exchange of remuneration in the relationship between them. This is even more obvious in national health systems, which are financed through taxes. While the systems differ in many details, including the degree of freedom to choose a healthcare provider, they all have in common that patients does not directly pay the provider. The price of the service is therefore not determined on the basis of the contract between patient and service provider but on the basis of the legal regime governing the relationship between the service provider and the organisations of healthcare. The right to receive medical treatment abroad and to claim reimbursement introduced by the ECJ fundamentally changed this framework: The patient can freely choose the service supplier (regardless of any restrictions in the domestic system) and must directly pay the supplier. Subsequently the patient can claim reimbursement. The ECJ therefore required the Member States which operate a benefit-in-kind system to allow for a deviation from this system.[21] It can therefore be said that the ECJ's case law introduced a

[20] V. Hatzopoulos, Killing National Health and Insurance Systems but Healing Patients? CMLRev 2002, 683; A. Cygan, Public Healthcare in the European Union: Still a Service of General Interest? ICLQ 2008, 529; F. Tacconi, Freedom of Health and Medical Care within the European Union, ZaöRV 2008, 195; W. Sauter, The Proposed Patient Mobility Directive and the Reform of Cross-Border Healthcare in the EU, TILEC Discussion Paper, 2008; J. van de Gronden, Cross-border healthcare in the EU and the organization of the national healthcare systems of the Member States, Wisconsin Int. Law J 2009, *to be published.*

[21] This is explicitly recognised by Section 13, Paragraphs 4 and 5 of the German Social Code Book Five (§ 13 Abs. 4 und 5 SGB V) which covers the public health system. According to this provision the public sickness funds may "instead of the provision of goods or services" reimburse patients for a treatment they received abroad. There is no such possibility for a domestic health service supplier.

market-based relationship in a sector which was previously not organised according to the logic of the market.

As a consequence of this the ECJ's judgements can be seen as the basis of an emerging common market for healthcare services. Two recent developments highlight this: On 2 July 2008 the Commission proposed a directive on cross-border patient mobility.[22] With this proposal the Commission aims to clarify and summarise the ECJ's case law. Interestingly, however, the proposed directive also contains a definition of the concept of concept of "cross-border healthcare" which covers more than the patient mobility. In fact, the concept includes four "modes of supply of healthcare":
"(1) Use of healthcare abroad (i.e.: a patient moving to a healthcare provider in another Member State for treatment); this is what is referred to as 'patient mobility';
(2) Cross-border provision of healthcare (i.e.: delivery of service from the territory of one Member State into the territory of another); such as telemedicine services, remote diagnosis and prescription, laboratory services;
(3) Permanent presence of a healthcare provider (i.e.: establishment of a healthcare provider in another Member State); and
(4) Temporary presence of persons (i.e.: mobility of health professionals, for example moving temporarily to the Member State of the patient to provide services)."

If this broad definition has any relevance, it shows the potential reach of Community legislation according to the view of the Commission. Hence, not only cross-border patient mobility, but also establishment of health service suppliers, e-health and movement of service providers are covered.

This broad approach coincides with a pending case of the ECJ. In *Hartlauer*, a German dental clinic wants to establish a subsidiary in Austria.[23] The Austrian authorities have rejected the application arguing that there was already a sufficient supply of dentists in the area where Hartlauer wanted to establish itself. Advocate General *Bot* applied Art. 43 ECT on freedom of establishment to this case and argued that a restriction could only be justified on mandatory requirements. He reasoned that they should be the same as in the cases on patient mobility.

[22] Proposal for a Directive of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare, COM (2008) 414 final.
[23] Case C-169/07, *Hartlauer*, Case pending.

To conclude, the ECJ's case law and the subsequent Draft Patient Directive as well as potential future cases of the ECJ in the area of free establishment show that in legal terms the provision and the reception of health services are increasingly considered as market activities. We can therefore speak of legal or institutional commodification of healthcare services.

3. Towards a substantive market?

The number of patients receive non-emergency medical treatment abroad is still very limited. The Commission estimates that cross-border healthcare represents around 1% of public expenditure on healthcare.[24] For the German public health scheme, it was 0,3% in 2007.[25] Other figures confirm the negligible size of cross-border healthcare. Among the 17 million patients treated in German hospitals in 2006, 54.000 came from abroad, but only 14.000 received non-emergency treatment. It is possible that this number may grow in coming years. In particular, in border regions or in the case of special treatment the impact of cross-border patient mobility may become more significant. However, it is likely that the potential for growth is limited.[26]

The potential for "Mode 3", i. e. the permanent presence of a healthcare provider in another country, may be much greater. While most domestic markets still seem very much dominated by national service suppliers, the presence of foreign companies may rise: With a growing number of privatised hospitals, healthcare providers may increasingly move across borders to establish permanent presences. For example, the Swedish company *Capio*, which considers itself as "one of the leading healthcare providers in Europe" maintains about 100 hospitals and special medical centres in Europe, including Sweden (26 units), Norway (six units), France (26 units), Germany (eleven units), Spain (20 units) and the United Kingdom (one unit).[27]

[24] Commission Staff Working Document Accompanying document to the Proposal for a Directive of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare, Impact Assessment, SEC(2008) 2163, p. 9. This coincides with figures from the United States: It is estimated that only 0.2% of the US health expenditure is spent on exports of health services (Figure for the later 1990s), WTO Secretariat, Health and Social Services, Background Note, S/C/W/50, 18 September 1998, p. 5

[25] L. Hajen, Europäischer Wachstumsmarkt Gesundheitsdienstleistungen zwischen Vision und Realität, Presentation at the Symposium „Gesundheitsdienstleistungen im europäischen Binnenmarkt", 24/25 November 2008, Institut für Europäische Gesundheitspolitik und Sozialrecht an der Goethe-Universität, Frankfurt/M, available at http://141.2.205.15/zgw/medsoz/Ineges-Konf/Hajen%20-%20Pr%C3%A4sentation.pdf

[26] Ibid.

[27] Information taken from http://www.capio.se/en/Capio-Presence/ (1 February 2009).

It has to be admitted that there is only a very limited empirical basis for the assessment of the actual extent of cross-border healthcare. Yet, many believe that there is generally a growing potential for the "health market". It has even been argued that healthcare could become a sixth *Kondratieff* cycle which may rise to 10-15% of GIP in a coming "Health age" in the 21st century.[28] In any event, it is clear that the transnational dimension of healthcare has not yet reached a significant size and it is hence too early to already assume substantive commodification in the healthcare sector.

4. Summary

To conclude the above arguments: The commodification of healthcare in Europe has many different faces. Sometimes, the commodification is pure rhetorical. Even though rhetorical commodification may have no legal and economic consequences, it should not be dismissed as language without meaning. Instead, rhetorical commodification is the first sign of a fundamental shift in the approach towards a particular activity. At the very least, it indicates the emergence of a new ideology, which may – but does not have to – pave the way for more advanced forms of commodification. Yet, we should not be surprised if we cannot observe dis-embedded markets at this stage.

The jurisprudence of the ECJ on cross-border healthcare and the subsequent publication of the European Commission's proposal of a Draft Directive on Patients' rights introduced a legal framework which may be used to establish a transnational market of healthcare. However, as in the case of rhetorical commodification, unless patients, healthcare providers and organisations of healthcare use this framework and engage in significant cross-border exchanges, the provision of healthcare will remain embedded in the social regulatory framework of the nation state apart from a few exceptions which can be accommodated without system changes. Only if the amount of cross-border activities reaches a level which can be called substantive commodification are we confronted with a dis-embedded market. Attempts to re-embed this market at a transnational level will only occur at this stage. This analysis does not mean that the current level of commodification is unproblematic. To the contrary: Since substantive commodification of healthcare in Europe may only be a matter of time, it would be prudent to start thinking about the possible framework for re-embedding healthcare at the EU level now.

[28] L. A. Nefiodow, Der sechste Kondratieff. Wege zur Produktivität und Vollbeschäftigung im Zeitalter der Information, 2001.

This, however, raises the question about the EC's competence in the field of healthcare. According to Art. 152 ECT the EC mainly has competences to support the Member States which keep most of the substantive competence in healthcare. A closer look at the EC's internal market competence in Art. 95 ECT suggests that there may be a basis for any measures – even regulatory ones – if the main focus of the measure is on removing obstacles to the four freedoms and competition.[29] The Draft Patient Directive is also based on this competence. It is therefore likely that future directives including regulation of healthcare may also be based on this provision if they aim primarily at the creation of the internal market.

IV. Trade in health services and WTO law

The impact of WTO's General Agreement on Trade in Service (GATS) on public health has been the subject of great public interest and debates.[30] Interestingly, however, the inclusion of health services in the GATS during services negotiations of the Uruguay Round did not spark much controversy. It was only in the run-up to the GATS 2000 negotiations that health services became a contentious subject in the WTO. One way of explaining this might be the different approaches of WTO members towards health services in the mid 1990s. Some Members may have regarded them as commodities in particular if those Members relied predominantly on private health systems. For many European countries, the question may not have come up in the 1990s, because they considered their systems to be immune from the GATS anyway due to the governmental character of healthcare provision.

1. Scope and impact of the GATS on health services

Health services are covered by the GATS unless they are supplied "neither on a commercial basis, nor in competition with one or more service suppliers" (Article I:3(c) GATS). Based on a cautious definition of commercial and competition developed in another context[31], it can be

[29] ECJ, *Tobacco Advertising*.
[30] A. Pollock/D. Price, Rewriting the regulations: how the World Trade Organisation could accelerate privatisation in health-care systems, 356 The Lancet (2000), 1995-2000; R. Adlung and A. Carzaniga, Health services under the General Agreement on Trade in Services, 79 Bulletin of the World Health Organization (2001), p. 352-364. See also S. Sexton, Trading Healthcare Away? GATS, Public Services and Privatisation, The CornerHouse Briefing, 2001; J. Hilary, The Wrong Model - GATS, trade liberalization and children's right to health, 2001; R. Chanda, Trade in health services, 80 Bulletin of the World Health Organization (2002) p. 158-163.
[31] M. Krajewski, Public Services and Trade Liberalization: Mapping the Legal Framework, JIEL 2003, p. 341-367.

assumed that health services provided through a national health service would not be covered by the agreement, because it is usually free at the point of provision ("neither on a commercial basis") and based on a monopoly ("not in competition with one or more service suppliers"). However, if there is competition between private and public health insurers or private and public hospitals or if doctors compete with each other for patients, the carve-out for governmental services according to Art. I:3(c) GATS would not apply. It can be argued that there is a general consensus of WTO Members that health services are covered by the GATS. In fact, the WTO's services classification explicitly includes these services. The classification distinguishes between health services provided by various professions (medical doctors, dentists, psychiatrists, nurses, midwives, paramedics, etc.), which are part of the category "professional services" and health and social services, which include hospital services and which constitute a separate group.[32]

The GATS defines trade in services through four modes of supply. Art. I:2 GATS states: "For the purposes of this Agreement, trade in services is defined as the supply of a service:

(a) from the territory of one Member into the territory of any other Member;

(b) in the territory of one Member to the service consumer of any other Member;

(c) by a service supplier of one Member, through commercial presence in the territory of any other Member;

(d) by a service supplier of one Member, through presence of natural persons of a Member in the territory of any other Member."

Article I:2(a) GATS covers the so-called cross-border supply or mode 1. It usually does not involve the movement of the service supplier or consumer across borders. Instead, only the service crosses the border. In health services, mode 1 is usually associated with telemedicine or diagnosis and medical advice through telecommunications (e-health). Supply of a service through mode 2 occurs if the consumer of one WTO member consumes a service in the territory of another member. This covers cross-border patient mobility. Mode 3 requires the commercial presence of a foreign service supplier in the territory of a WTO member. Health services trade through mode 3 involves *inter alia* the establishment of hospitals or clinics in another country. Mode 4 requires the presence of natural persons. It is usually associated with the supply of medical services or services of nurses and midwives through the temporary movement of professionals providing these services in another country. In sum, the scope of

[32] Services Sectoral Classification List, MTN.GNS/W/120 as attached to the Scheduling Guidelines.

the GATS regarding healthcare is therefore almost identical with the scope of the notion of "cross-border supply of health" as defined in Paragraph 10 of the Draft Patient Directive mentioned above.

The actual impact of the GATS on health services depends largely on the scope and limitations of the specific commitments of the WTO Members in health services. WTO Members have made commitments in health professional services and hospital services even though the overall amount of these commitments seems limited. In particular, many commitments contain quantitative limitations such as economic needs tests or limitations of the number of beds, heavy equipment or doctors per hospital. Often these limitations are based on national or regional health plans. One particular interesting example in the present context is the limitation of the commitments of the United States concerning Mode 2 in hospital services. The U.S. limited "public reimbursement of expenses" to facilities in the U.S.[33] In other words, a US citizen who received medical treatment in Europe cannot claim the expenses from public health schemes. It should be noted that the EC schedule contains no such limitation. Hence, a EU citizen may travel to the US to receive hospital or non-hospital services and claim the expenses from the domestic health system on the basis of the GATS commitments in conjunction with the ECJ's jurisprudence on patient mobility.

2. Commodification of health services in the WTO context

Taking the approach to commodification developed above, it can be argued that "rhetorical commodification" existed in the international trading system since the Uruguay Round negotiations. Since the CPC and the GATT secretariat's list of services and sectors included health professional and hospital services, there was never any doubt that these services were subject to the GATS and could become an area of transnational liberalisation. It can also be said that the GATS provides a legal framework for the commodification of health services. If WTO Members want to subject their health systems to market-based structures, in particular by encouraging foreign investment and competition, they can support this by fully committing health services to the disciplines of market access and national treatment. In particular, a full commitment in market access requires the abolition of all quantitative restrictions both with regard to the cross-border mobility of patients (Mode 2 of the GATS) and to commercial presence of foreign providers of health services (Mode 3 of the GATS).

[33] Schedule of Specific Commitments of the United States of America, GATS/SC/90, 14 April 1994.

Similar to the observations regarding the EU market on healthcare it is difficult to determine the scope of substantive commodification of healthcare at a global level. It can be assumed, however, that the extent of commodification is larger. It is also estimated that cross-border healthcare will increase. The international consultancy firm Deloitte claims that the total number of patients seeking medical treatment abroad will raise from 750.000 in 2007 to 10 Mio. in 2012.[34] This development may still not be significant enough to assume dis-embedded healthcare markets at a global level anytime soon. Yet, different countries will be affected differently by this development.

The question therefore arises which institutions might be suitable for attempts to regulate the cross-border supply of health services and to re-embed healthcare markets. Even though the WTO is not a regulatory organisation, some of its instruments contain regulatory nuclei. For example, the Reference Paper on Telecommunications could be seen as an attempt to accompany the liberalisation of telecommunications services with regulatory principles at a global level. However, the GATS does not contain a specific regime for health services regulation like the regime for telecommunications. A Reference Paper for health services and special disciplines on domestic regulation in health services have been suggested in the literature[35], but there are no negotiating proposals for such instruments in the current negotiations. It is therefore unlikely that WTO members will agree on common principles and disciplines for the regulation of international trade in health services, because of the fundamental differences of national health systems. Unlike in telecommunications there is no "agreed model" of health services liberalization, which can be suggested as a reference for a large number of countries. This raises the question whether other institutional organisations, such as the WHO, may contribute to the efforts of re-embedding transnational healthcare markets.

V. Conclusion

This paper suggested a typology of three forms of commodification (rhetorical, legal and substantive) of public services which were not subject to market processes until a few years ago and which underwent a significant transformation in most European countries in recent

[34] As cited by Hajen, above note 21.
[35] D. Luff, Regulation of Health Services and International Trade Law, in: A. Mattoo/P. Sauvé (eds), Domestic Regulation and Service Trade Liberalization, 2003, at 217.

times. The paper applied this typology to healthcare in the European and the WTO context. Based on this the paper's two main arguments are: First, the distinction between different forms or levels of commodification in transnational contexts presents us with an analytical tool to differentiate between different changes in the provision of healthcare or of other public services. This may clarify our understanding of the process of commodification of governmental activities in general. Second, the distinction between the three level also indicated that we should only expect dis-embedded markets once a process of substantive commodification took place. This makes the analysis of and the political reaction to dis-embedding processes difficult, because the development of substantive commodification may be gradual while the creation of a legal framework which allows for such commodification is more visible.