4. Services Trade Liberalisation

Introduction

A service is "a product of human activity aimed at satisfying a human need which does not constitute a tangible commodity" (Sinclair, 2000). It thus includes such areas as education, energy, finance, health, insurance, transport, travel and tourism. According to UNDP (1999), international trade in services is about 60 per cent of global value added as a percentage of Gross Domestic Product (GDP) and employment. It is 68 per cent of the value added for high-income countries and 38 per cent for low-income countries (cited in Crosby and Vielma, 2000). Cross-border trade in services in 1999 was US$1,350 billion, which was equivalent to 20 per cent of total cross-border trade. As a result of their growing importance world-wide, services have been incorporated into the multilateral trade framework under the General Agreement on Trade in Services (GATS). They are also increasingly being incorporated into regional processes.

While trade rules for goods have a long history, those for services are new, very complicated and plagued by a general lack of available data for assessing their scope and impact. More importantly, trade in services possesses characteristics that make it different from goods and so warrant more careful deliberation and attention in the liberalisation process. For example, services may be consumed within the national border via the right of establishment (commercial presence). This is part of the privatisation, deregulation and commercialisation agenda and hence has implications for a country's development strategies as well as for how resources are allocated. While trade liberalisation in services in either multilateral or regional agreements is not explicitly a privatisation agreement, it is undeniable that in order for a service to be liberalised it must first be privatised. This privatisation agenda is carried out through the International Monetary Fund (IMF) and World Bank.

Poor people's access to water, schooling and affordable health care must be protected.

Services liberalisation and the GATS have implications for health care/health standards, job security and conditions of work for a large number of people. There must therefore be a focus on their social equity and social justice dimensions. Poor people's access to water, schooling and affordable health care must be protected. In terms of water, for example, evidence from Bolivia shows that privatisation dramatically increased its cost and reduced the access of the poor. Similarly, the imposition of undifferentiated user fees for cost recovery schemes in India and South Africa has led to the poor not having access to essential water services. In Kwa-Zulu Natal, South Africa, lack of access to safe drinking water has been implicated in the outbreak of cholera (Hall, 2001).

The recognition of the pivotal role of services in human life has led the United Nations Sub-Commission on the Promotion of Human Rights to pass a resolution reiterating the "fundamental importance of the delivery of basic services" (August 2001). The Commission's report also highlighted the potential human rights implications of the liberalisation of trade in services. It further reaffirmed that government must play a role in ensuring the availability, accessibility and quality of basic social services.

Reduced access to and the likely un-affordability of privatised and liberalised services such as water and health care will greatly affect women because of their role in social reproduction. It is now recognised that women are likely to be over-represented among those suffering from untreated injuries/diseases, malnutrition/hunger and illiteracy/innumeracy. Services trade reforms and trade liberalisation policies that do not take these factors into account are unlikely to yield much benefit to women in their multiple roles as caregivers, household workers, entrepreneurs, farmers and workers in the informal and formal sectors of the economy. Economic decision-makers in this area need to be aware of and sensitive to these issues. They must also ensure that such policies are complemented by similarly gender-aware social and labour market policies.

The GATS framework for services liberalisation is all-inclusive and has a built-in agenda for future negotiations, which could mean the liberalisation of all sectors of the service economy. Thus GATS is of tremendous importance to developing

economies. However, while it potentially has tremendous development, social and gender equity consequences, it is an area of increasing complexity and is much less understood by trade negotiators and civil society alike than other areas of trade.

The General Agreement on Trade in Services (GATS)

The GATS covers all services except those "supplied in the exercise of government authority" (Article 1). Article 1.3(c) clarifies 'government authority' as "any service which is supplied neither on a commercial basis nor in competition with one or more service supplier". Thus only a few services are excluded (e.g. central banking and the military). Whether social security is included is a topic of contention. Although government procurement is exempted from some GATS provisions (Article XIII), it is part of the built-in agenda for future negotiations.

Campaigners against GATS in the UK protest the selling of basic services such as water, transport, health care and education
PEOPLE & PLANET/WWW.PEOPLEANDPLANET.ORG

Box 4.1 Services and the Nature and Scope of the GATS

Services sectors, as understood by the General Agreement on Trade in Services, include:

- provision of water, gas and electricity;
- environmental services such as sewage and sanitation;
- financial and banking services;
- telecommunications and postal services;
- insurance and insurance-related services;
- business services such as accounting, real estate services and advertising;
- social and human services such as health care, education and libraries;
- tourism and tourism-related areas such as travel services;
- construction;
- entertainment;
- professional services, such as in engineering, architecture and medicine;
- media (television and radio broadcasting);
- transportation and transport-related services including by land (e.g. buses), shipping, air cargo handling, storage and warehousing;
- personal services such as hairdressing.

The GATS sets rules on how countries treat foreign services providers and seeks to regulate all measures affecting trade in services. These include government laws and policies, and regulatory and administrative rules such as grants, subsidies,

licensing standards and qualifications, limitations on market access, and food safety rules pertaining to hotels, restaurants and the entertainment sector. The GATS also covers economic needs texts and local content provision, nationality and residency requirements, technology transfer requirements, restrictions on ownership of property or land, and tax measures that affect the foreign provision of services.

Services can by supplied by any of four methods or modes of delivery:

- Mode I: cross-border supply – services supplied from one country to another (e.g. international telephone calls).
- Mode II: consumption abroad – consumers or firms making use of services in another country (e.g. tourism).
- Mode III: commercial presence – a foreign company setting up subsidiaries or branches to provide services in another country (e.g. banks).
- Mode IV: presence of natural persons – temporary (not yet clearly defined) entry of persons to provide a service (e.g. management consultants).

The GATS architecture

GATS has two main parts: (i) the framework agreement containing general rules and disciplines; and (ii) the national 'schedules' under which individual countries list specific commitments on services sectors and on activities within those sectors. Every WTO member is part of GATS but not all the agreement's rules are universal. Countries can choose which sectors to include and which modes of supply to commit to which of its specific obligations. GATS is constructed around the following core elements:

- *Most Favoured Nation (MFN)* – i.e. non-discrimination among WTO members. Services concessions offered to one member must apply to all other members. This is a general obligation that does not have to be scheduled. However, a country can list MFN exemptions that will be phased out over time.

- *Transparency* – this currently means that governments must publish their schedule of sectoral commitments. However, some governments would like to include the identification of domestic regulations that may be trade restricting. Some would also like to include certain notification procedures, including the notification of draft legislation.
- *National treatment* – a country must give foreign suppliers treatment that is equal to the best treatment provided to domestic services and services suppliers. This only applies to sectors and modes of supply to which a country has made specific commitments.
- *Market access* – this prohibits numerical limits on services or services providers even if the regulation applies to both national and foreign suppliers (i.e. there is national treatment). Technically, it only applies to sectors and modes for which governments have taken commitments.
- *Built-in commitment* – to continuous liberalisation through periodic negotiations starting with GATS 2000.
- *Positive list* – a list of services sectors that a country undertakes to liberalise (the current model and one the South supports).
- *Negative list* – some Organisation for Economic Cooperation and Development (OECD) countries are tending to favour an approach that would subject countries to liberalisation in all sectors, except for those it puts on a 'negative' list of exclusion.
- *Bottom up* – this implies that certain of the GATS' specific obligations, namely market access and national treatment, apply only to those sectors positively listed by a government in its individual schedule. The bottom up approach also allows governments to list (at the time of signing) exceptions and limitations on coverage in these sectors.
- *Top down* – all measures and sectors are covered unless they are explicitly excluded. GATS rules apply to all modes of supply or consumption of a service internationally. Also, certain GATS rules apply to all services sectors – even those

where member governments have made no specific commitments in their country schedule (so-called horizontal rules such as MFN and transparency).

Box 4.2 highlights some of the commonalities and differences between the GATS and the GATT 1994.

Box 4.2 GATS and GATT 1994: Commonalities and Differences

The GATS and the GATT 1994 share some commonalities and differences, including:

- **both agreements incur horizontal commitments of Most Favoured Nation (MFN) – the GATT's non-discrimination obligations specifically relate to goods and products while those of the GATS relate to both services and services providers;**
- **both agreements are based on national treatment, but there are limitations on these obligations in the GATS;**
- **both agreements include an investment dimension, the GATT in terms of Trade-Related Aspects of Investment Measures (TRIMs) and other Annex 1 agreements and the GATS in terms of modes of supply, especially commercial presence (foreign direct investment);**
- **unlike the GATT, which mainly addresses 'border measures', the impact of the GATS on domestic regulatory regimes is broader, affecting and covering regulator reform (frequently associated with privatisation, de-regulation and commercialisation);**
- **the GATT applies to the product, the GATS applies to product and provider as well as the way the service is provided.**

In examining the effects of the services agreement, it is important to keep in mind the following:

- There is a strong tradition in the services sector of regulating to protect consumers and the environment, provide

security, protect public morals and provide prudential measures (UNCTAD, 2002b). The GATS recognises the sovereign right of a country to regulate services for legitimate purposes. Its preamble also allows for the introduction of new regulations on the supply of services in order to meet national policy objectives (see also article VI on domestic regulations).

- GATS commitments do not just apply to the central government but to all levels of government: local, parishes (provinces) and even to non-governmental organisations (NGOs) and community-based organisations "acting on the basis of authority delegated to them by the state".

- It is not enough to simply list a sector positively. A country must also list the inconsistent measures it has affecting those sectors (negative list) if it wants to maintain those protections or it will lose them. Dispute settlement rulings have indicated that "any errors and omissions will be costly for the defending government" (Sinclair, 2000).

- The GATS has already had a tremendous negative impact on the Caribbean (the EC Banana case) and poses further challenges especially in the area of culture/heritage and tourism (e.g. the Canadian Magazine case) (see box 4.3).

Current GATS negotiations

The GATS is a framework agreement that provides for "progressively higher levels of liberalisation of all services". Article XIX mandates negotiations to increase services trade liberalisation by entering into more or deeper specific commitments in market access and national treatment starting in 2000. In addition, other GATS provisions mandate the start of negotiations to develop disciplines on domestic regulation (Article VI.4) as well as developing new GATS rules, including on trade-distorting subsidies (XV), government procurement (XIII) and restrictions (such as the development of an emergency safeguard mechanism (X).

To date the GATS negotiations have been focused on the process of submitting 'requests' and 'offers' for service areas that countries want their trading partners to further liberalise.

The GATS 2000–2005 round of negotiations foreshadows fundamental changes in domestic services policies … and could weaken social services and social protection programmes.

Box 4.3 The Impact of GATS: Two Examples

In the precedent-setting EC Banana case, a WTO panel and the Appellate Body of the GATS found most features of the EC's banana import regime to be inconsistent with its WTO obligations. The USA (supported by Latin American producers) had complained that the EC was granting 30 per cent of import licences to former British and French Caribbean colonies. The EC appealed, stressing that changing this would destroy the livelihoods of tens of thousands of small producers, particularly in the Caribbean. Even though the EC had attained a formal waiver from the GATT rules on goods, the import regime was found to violate GATS because it affected the wholesaling and distribution of the product (i.e. services). The same measure was therefore found to be consistent with one agreement but inconsistent with another. The case also illustrates: (a) the danger of not making a specific commitment; and (b) that making such an exclusion in certain areas does not free one from challenges in another.

The Canadian Magazine case is a reverse parallel of the EC Banana case. Canada had introduced certain measures such as higher postal costs and advertising taxes to protect its magazine publishing industry from foreign competition. Here an ostensibly GATS-related measure (Canada had taken no commitments in the area in question) was found to be inconsistent with GATT 1994 because of its impact on goods (magazines). The trend has been that, in disputes concerning any particular measure, a WTO panel will apply the most restrictive provision under the agreements. Exemptions, exclusions and exceptions are interpreted narrowly.

This would expand market access to new areas as well as eliminate restrictions on sectors already committed to in country schedules.

The GATS 2000–2005 round of negotiations foreshadows fundamental changes in domestic services policies. It is likely

to have a 'lock-in' affect on de-regulation and privatisation and could weaken social services and social protection programmes. This has advantages and disadvantages for issues of development policies, human capital development, gender equality, the protection of natural resources, and land and other property rights. Advantages lie in the extent to which countries can: (a) exploit the GATS provisions and strategically use foreign suppliers to decrease under-capitalisation of domestic firms; (b) increase the diffusion and development of technology; and (c) increase the provision of costly services at better prices and for a wider cross section of citizens through carefully regulated foreign capital inflow.

However, in order for trade in services to achieve such positive effects, it needs to be carefully regulated by governments. Danger exists if large, uncompetitive and unaccountable foreign suppliers are simply substituting for domestic monopolies (Crosby and Vielma, 2000). It is generally assumed that foreign suppliers are competitive and bring better services but this is not always the case. They have been known to practice what is called 'cream skimming' (e.g. insurance companies in Latin America focus on the rich but do not offer services to the working class and poor because this is not profitable).

Moreover, it is feared by many social activists that the GATS-oriented liberalisation of services and discussions about domestic regulations having to meet particular tests – necessity and proportionality, etc. – is likely to negatively affect governments' willingness to regulate proactively to meet social and environmental concerns.

The domestic regulations debate

Domestic Regulation (Article VI) has been called GATS' 'Pandora's box' (Sinclair, 2000). It is the area of the most tension between the EU and the US and between the QUAD as a whole and the South. Article VI poses two tests for domestic regulations that could have a far-reaching impact on governments' authority: (i) necessity test (not more trade restricting than necessary); and (ii) legitimacy test (to achieve legitimate interest). The two are very vague and the subject of much discussion. Since the issue of what is necessary and what is legitimate is quite subjective and may differ from member to mem-

ber, there is quite a lot of room for disputes. Typical examples of possible legitimate objectives include protection of consumers, quality of service, competence of suppliers and integrity of the market. Many GATS watchers argue that these tests provide for closing any loopholes left by the MFN, national treatment and market access provisions.

Trade negotiators from developing countries are also uneasy with the push for *a priori* transparency. They believe that it makes domestic regulations that are crucial for promoting sustainable development (especially in tourism) very vulnerable.

Trade negotiators from developing countries are ... uneasy with the push for a priori transparency. They believe that it makes domestic regulations that are crucial for promoting sustainable development ... very vulnerable.

The subsidy issue

There is a big question as to what is a trade-distorting subsidy in the context of services and the GATS. From the point of view of some governments, such as the US, it confers a commercial benefit or advantage above and beyond what would normally be there. In the GATT 1994 two conditions are necessary for a subsidy to exist: (i) commercial interest; and (ii) specific advantage. This issue of commercial interest is central since it can determine to some extent whether or not social services are covered. One critical aspect might be who receives the benefit: the supplier or the consumer (citizens). It should be noted that under national treatment, countries can protect subsidies on some grounds. The US, for example, does this for its parks, national endowment of the arts, etc. However, questions are being raised about this.

Services liberalisation and developing countries

The services sector is a high growth area in many developing countries. It provides income and economic empowerment opportunities in industries such as, for example, data processing, tourism and banking in South-East Asia, India and Jamaica. However, services are also quite a volatile sector where there is tremendous international competition.

Within the GATS framework many developing countries have agreed to general obligations, including the provision of MFN treatment for all foreign services providers as well as transparency of services liberalisation commitments. Some

Many countries of the South are now in their second decade of structural adjustment programmes (SAPs). These promoted de-regulation, commercialisation and privatisation of services, yet the lives of the poor and the marginalised have not improved significantly. Sometimes they have worsened.

member countries also agreed to specific commitments on national treatment and market access in sectors they open for liberalisation (Spieldoch, 2001). All these allow foreign suppliers to enter national markets with little restrictions. These firms can, for example, establish hospitals, medical practices and pharmaceutical companies and hire health care workers.

Although defenders of the GATS argue that governments can protect their basic services by only listing those services that they want to include in GATS negotiations, this so-called positive list approach does not ensure that governments have control over their basic services. Such arguments ignore the strong "political and economic forces outside the GATS negotiations that pressure governments, such as the effects of the World Bank and IMF Structural Adjustment Programmes, poverty and burden of debt payments that force countries into untenable decisions" (Riley, 2002).

Many countries of the South are now in their second decade of structural adjustment programmes (SAPs). These promoted de-regulation, commercialisation and privatisation of services, yet the lives of the poor and the marginalised have not improved significantly. Sometimes they have worsened. Both SAPs and the WTO trade liberalisation process share some common features. While SAPs led a co-ordinated attack on the state and helped to foster the creation of an enabling environment for capital – free trade zones and dismantling import substitution structures – WTO rules and policies bolster the search for competitiveness and profit maximisation by transnational corporations (TNCs) by knocking down barriers to trade. Since trade policy is not isolated from other macro-level policies (such as development aid, SAPs, investment policies, etc.) it brings about changes in domestic labour legislation, social insurance programmes and policies as well as new forms of regulations.

Both SAPs and explicit trade liberalisation under the multilateral framework affect the distribution of income within and between countries by their impact on wages and prices and through changes in the ownership structure of national resources (Roldan, 1997; cited in Joekes, 1999). Yet prescriptions for privatisation and reduction of government expenditures take no account of how they may intensify poverty and deprivation. Both the IMF and the World Bank argue that

their programmes will achieve 'positive outcomes'. However, it needs to be asked what is considered to be a positive outcome, and for whom it is positive (Fall, 1999).

Gender Issues in Trade in Services Liberalisation

Critical concerns regarding the liberalisation of services from a gender perspective include its impact on access to and availability of public services (such as health care and education) and natural resources (such as water and energy). Other pressing concerns include:

- government's ability to regulate the quality of health care;
- the nature of the employment of women (the conditions of work and whether they differ significantly from those in the manufacturing and export processing sectors);
- the treatment of the movement of natural persons (very important for women, who are increasingly part of the international workforce as migrant, seasonal and guest workers, etc.);
- sex tourism and trafficking in women and girls, which is also an area that needs urgent discussion and corrective remedies;
- the sustainability of employment, wages and incomes of women workers *versus* male workers.

Critical concerns regarding the liberalisation of services from a gender perspective include its impact on access to and availability of public services ... and natural resources.

Over the last ten to fifteen years the services sector has been a growing proportion of the economies of almost all countries. Despite this, it remains significantly under researched. The available data, however, points to its importance as an area of employment for women. From the perspective of gender analysis, activities that fit into the services sector can be grouped into three broad and interrelated categories:

1. *Traditional services:* domestic services, small-scale commerce, government administration and the social sector (health and education).
2. *Modern business services:* information processing and business services (law, accountancy, management consultancy

Overall, trade liberalisation and globalisation are contributing to a rapid expansion of the informal sector. In terms of services, the major areas are small-scale commerce and catering.

and marketing). Leading edge technological activities such as software design, computer programming and financial services are often described as customised higher modern services whereas banking and insurance are often described as high income personal services. Also classed as service firms are intermediary buying agents, which are pervasive in the clothing industry.

3. *Essential/infrastructural services:* including transport, energy and water.

It is well recognised that women have been incorporated into traditional services such as the public sector, social welfare sector and government administration in most countries. They also continue to make up the vast majority of workers in the low-wage, benefit-scarce traditional services (including cleaners, waitresses and sales persons). With regard to modern services, women tend to predominate in the information-processing sector. Research in the Caribbean, for example, shows workers in the data entry segment to be almost exclusively women. They provide data entry for the processing and coding of information or credit cards, airline/rail systems transactions and mail orders. The establishment of 'call centres' is also becoming an important source of employment for women in some developing countries. Women are not yet found in significant numbers in software and programming work and occupy the lower rungs. However, this area holds potential for higher pay and more jobs for educated and middle class women.

Overall, trade liberalisation and globalisation are contributing to a rapid expansion of the informal sector. In terms of services, the major areas are small-scale commerce and catering. The agricultural link is informal cross-border and domestic trading in vegetables, etc. Research in Africa and Latin America points to women's heavy concentration in activities such as prepared food and sewing/dressmaking while men are found in "small-scale labour-intensive and low profile skill enterprises" (Bifani-Richard, 1999) such as 'patch and mend' repair shops. Some women gain jobs or buttress their sources of income by increasing trading activities. Others, however, lose the livelihoods that were linked to selling foodstuffs and meals as these activities are significantly affected by

Laying water pipes in Lesotho

INTERNATIONAL FUND FOR AGRICULTURAL DEVELOPMENT (IFAD)/G. BIZZARRI

the availability of imported prepared foods. Repair shop activities are also affected by imported spare parts.

In trying to isolate the gender impacts of services liberalisation, this chapter will focus on a case study approach to specific sectors: health, education and tourism. These were selected because they are those with the most commitments in the GATS from developing countries.[3] The health sector will be the template for a number of reasons but mainly because it has been the least explored from the perspective of gender analysis of trade liberalisation. Education will only be looked at briefly as it has been well discussed in the literature on SAPs. Some focused attention will be placed on tourism, as it is an area of great employment opportunities, both formal and informal, for women in many developing countries. It is also seen as a critical driver in the trade-led development agenda.

3 Although the topic of water is pervasive in the privatisation debate, it is not addressed here because its liberalisation process is still at a rudimentary stage in most developing countries.

Health Care[4]

Health care services are:

- public goods;
- historically non-commercial in nature;
- traditionally the exclusive domain of domestic policy;
- linked in critical ways to other sectors of the economy.

These special characteristics are important for gender and social equity and hence require caution with regard to liberalisation (see box 4.4).

Box 4.4 Health Services under the GATS

The scope of health services under liberalisation includes hospital management, clinics, health care infrastructure, professional services provided by doctors, nurses and paramedics, and related services such as education/ consulting in the heath sector. The GATS covers specialised services of doctors, deliveries and related services, nursing services, physiotherapeutic and paramedical services, all hospital services, ambulance services, residential health facilities and services provided by medical and dental labs. It treats professional services provided by doctors and nurses separately from hospital services. Regulations on trade in health targeted in the on-going GATS negotiations include: qualification and licensing requirements for individual health professionals; approval requirements for institutional suppliers; and rules and practices governing reimbursement under mandatory insurance schemes.

Source: **Chanda, 2001**

Despite this, however, the health sector is a target of increasing deregulation, commercialisation, privatisation and liberalisation. It is also a source of growing international trade. To

4 This section is an adaption of Spieldoch (2001) and also relies heavily on Chanda (2001) and WHO (2001).

date about 100 WTO members have scheduled commitments on health services. There is some debate as to whether 'public services' such as health care are exempt from the GATS. As noted earlier, exemption applies to services that are "supplied neither on a commercial basis, nor in competition with one or more service suppliers". It is difficult for governments to claim this of their public services, however, because many of them have privatised at least some of these. Private contractors often compete with government for their contracts and supply services on a commercial basis. There are important challenges around distinctions and definitions of public and private ownership and responsibility in the provision of these services.

The outcome of negotiations around domestic regulations may jeopardise a nation's ability to create and provide proper standards of health care.

From the point of view of those concerned with social and gender equality and sustainable development, one of the key areas in the GATS debates is whether countries will have the sovereignty to regulate trade that could be potentially harmful to their communities and environment. The outcome of negotiations around domestic regulations may jeopardise a nation's ability to create and provide proper standards of health care. Article IV of the GATS mandates that government regulation is permitted as long as it does not constitute 'an unnecessary barrier to trade'. WTO members need to figure out exactly what this means. Domestic regulations are largely contentious as well as subjective. It is not unlikely that a governmental measure designed to ensure quality health care for its citizens could be seen as an unnecessary barrier by a foreign supplier of services and thus lead to challenges in the WTO.

Women and men play different roles in health care. Women are usually the caretakers of families and communities. They minister to the sick and help in post-hospital recovery for children, spouses and the elderly. In the formal health services sector, women are found predominately in caring roles as nurses and nursing aides as well as being doctors and other allied professionals. The four modes of supply in the GATS noted above – cross-border supply, consumption abroad, commercial presence and movement of natural persons – also apply to the health care sector. The beginnings of an approach to gender analysis of the GATS and health care might be to sketch out the gender and social implications of liberalisation in this sector by modes of service delivery. Clearly this is an area for further research.

Box 4.5 Factors Driving the Liberalisation of Health Care

Some of the factors that are driving the liberalisation of health care include:

- **a decline in public sector expenditure;**
- **a rise in the private sector as a significant participant in health care;**
- **increased mobility of consumers and health services providers;**
- **decreased travel costs and greater ease of travel;**
- **technological advances enabling the cross-border delivery of many health services;**
- **investment opportunities in the health care sector (due to investment liberalisation regulations);**
- **an increase in the demand for health care (due to rising income levels and aging populations);**
- **increasing portability of health insurance (with insurance liberalisation).**

Mode I: cross-border supply

Cross-border supply takes place when the service itself crosses the border from one country to another. Examples are telecommunications, health insurance, shipment of lab samples, diagnosis and clinical consultation via traditional mail channels and the electronic delivery of telehealth services. Telehealth uses "interactive audiovisual and data communications to provide services such as diagnosis, second opinions, lab testing, surveillance, consultations, transmission of and access to specialised data, records, and information, and continuing education and upgrading of skills" (Chanda, 2001). Other aspects of telehealth include telepathology, teleradiology, and telepsychiatry. Commonwealth countries significantly involved in telehealth are Bangladesh and India. India, for example,

provides telepathological services to Bangladesh and Nepal and is also involved in the outsourcing of medical transcription services. Medical transcription is increasingly being outsourced to developing countries and is potentially a growth area for women's employment.

Opportunities for developing countries

According to the World Health Organization (WHO), these include access to advances in health care and to the services of professionals from other parts of the world, enhanced diagnostic and appropriate patient management facilities and improved quality of health care (Than Sein and Chang Rim, 2001).

Social equity and gender implications

Social equity issues arise with regard to cross-border supply of health services. Some of the likely positive impacts include:

- increased equity and wider access to better quality health care due to the potential expansion of services and access to remote and rural areas;
- reduced need for travelling for medical/health services (and hence reduced time needed and cost of transportation involved) due to the availability of services such as tele-diagnosis, imagery and treatment;
- longer periods of retention of medical and professional staff in remote or rural areas due to the increasing availability of professional support and updating with subjects of expertise via tele-education and conferencing;
- decreased migration abroad (and to urban centres) of health care personnel due to access to telemedical education and professional support.

However, some negative social equity impacts of cross-border supply may occur:

- if investment for telecommunications infrastructure is financed by public investment to the disadvantage of the primary, preventative and curative health care sector (this may also reduce overall spending on the social sector, thus worsening vertical equity in the society);

Health care workers ... in low-skilled positions, the majority of whom are women, are often left without safety nets and safeguards to ensure new jobs and decent living conditions.

- if government revenue is re-allocated to establish specialised health centres and away from rural areas, there will be fewer services available to poor men and women living in these areas;
- if the cross-border trade continues to be one way – from North to South – due to licensing problems, this will drain foreign exchange from developing countries and have a negative impact on local health care infrastructures;
- if user fees or health insurance are involved in terms of access to health services, people with low incomes will have less access.

Gender equality issues include:

- The infrastructure for telemedicine could take away from expenditures on basic health care and infrastructure that are important to women (health clinics, preventive care, etc.). Such a trend may only benefit the rich and help to further exacerbate imbalances in health service between rural and urban areas. Thus overall it may reduce equity in health care.
- Having different medical standards across countries brings in ethical and legal considerations having to do with services operating outside national boundaries. This poses significant risk factors for women's health – particularly their reproductive rights – given the tenuous nature of their social status and rights in many countries. In addition, there is the issue of how telemedicine is affected by and impacts on cultural rights and nuances, privacy of information rights and health rights.
- Health care workers could lose their jobs with the decrease in face-to-face health care provision. Those in low-skilled positions, the majority of whom are women, are often left without safety nets and safeguards to ensure new jobs and decent living conditions.
- By tabling commitments to further liberalise health insurance, countries may be creating a situation where the elite has access while the poor, the majority of whom are women,

are left uninsured. For example, Canada is among the developed countries that have tabled commitments on health insurance.

Mode II: consumption abroad

Consumption abroad refers to individuals who travel to another country for medical diagnosis and treatment – a significant part of the trade in health services. It also includes the movement of health professionals and students to receive medical and paramedical education and training abroad. The main Commonwealth developing country supplying such services is India. India also excels in providing treatment such as bypass surgeries and transplants for patients from more wealthy Commonwealth countries such as the UK (and the US) at one-fourth or one-fifth of the cost. Developing countries may also be a source of traditional medicines (e.g. India and Bangladesh in areas such as Ayurveda and Unani).

Opportunities for developing countries

According to WHO, consumption of medical/health services abroad offers opportunities for better health care, lower prices to consumers and increased revenues to government (from fees paid by foreign patients). "Increase[d] revenue from investment in the sectors can help to upgrade health care infrastructure, knowledge and skills" (Spieldoch, 2001). However, there are also considerable social equity and gender implications.

Social equity and gender implications

Some of the trends that may impact more positively on social equity include:

- foreign exchange inflow from foreigners purchasing health care being invested in the domestic health sector, helping to upgrade infrastructure, knowledge, skills and technical capacity;
- inflow of revenue into the health sector from foreign consumption can bolster government expenditure on the local primary and emergency care sector.

However, as with Mode I, potentially negative equity considerations linked to consumption abroad may include:

Privatised hospitals may choose more qualified doctors and health care providers for foreigners who can pay while leaving the less qualified doctors to the general public who cannot.

Box 4.6 Emerging Areas in Trade in Health Services

Emerging areas in trade in health services include:

- **telehealth, telemedicine and the integration of information technology with health can be sources of capacity-building in developing countries, e.g. the University of Zambia gained capacity in becoming an intermediary for resources and information in the country;**
- **trade in health-related education services include joint ventures between universities and medical schools or training institutions across borders, e.g. Australia has strong recruiting of students from abroad and joint ventures with foreign universities and institutes;**
- **home-based health care services (assisted living care for the disabled and the elderly and services for persons with chronic conditions or recovering from surgical procedures);**
- **distance consulting in traditional healing;**
- **health tourism;**
- **spas and rehabilitation.**

- internal brain drain (health personnel switch into more lucrative private sector), leading to shortages in the public sector and rural areas;
- allocation of public funds to subsidise private hospitals that cater to foreigners and the wealthy at the expense of the poor;
- privatised hospitals may choose more qualified doctors and health care providers for foreigners who can pay while leaving the less qualified doctors to the general public who cannot;
- potential for exacerbating dual market structure and possibly create further differentiation (i.e. speciality hospitals that only attract foreign patients);

- fewer beds, doctors and trained personnel for the country and the poor;
- lack of attention to diseases affecting the poor (and women) and more attention and resources for those illnesses that affect upper income groups and foreigners.

Studies need to be done to ascertain the gendered impacts on both services providers and consumers. As with Mode I, the increasing portability of insurance, usually only available to high-income earners in developing countries, is also a critical factor facilitating the health service trade. This also raises the same gender equity questions of women's likelihood of access to portable insurance *versus* their dependence on health services offered by the public sector.

Mode III: commercial presence

Commercial presence exists when a foreign company sets up a subsidiary or branch in another country (e.g. hospitals, clinics, diagnostic and treatment centres and nursing homes). Countries with significant involvement in this area of the health sector are India, Indonesia, Sri Lanka and Thailand. Some Commonwealth countries are involved in regional care networks, for example, India, Malaysia, Singapore, Sri Lanka and the UK with the (Singapore-based) Parkway Group. Mode III opens up the health services sector to foreign equity participation as a way of supplementing government investment and upgrading heath care infrastructure.

Opportunities for developing countries

Opportunities include reduction of the financial pressures on government, more and better health care and improved delivery of health care.

Social equity and gender issues

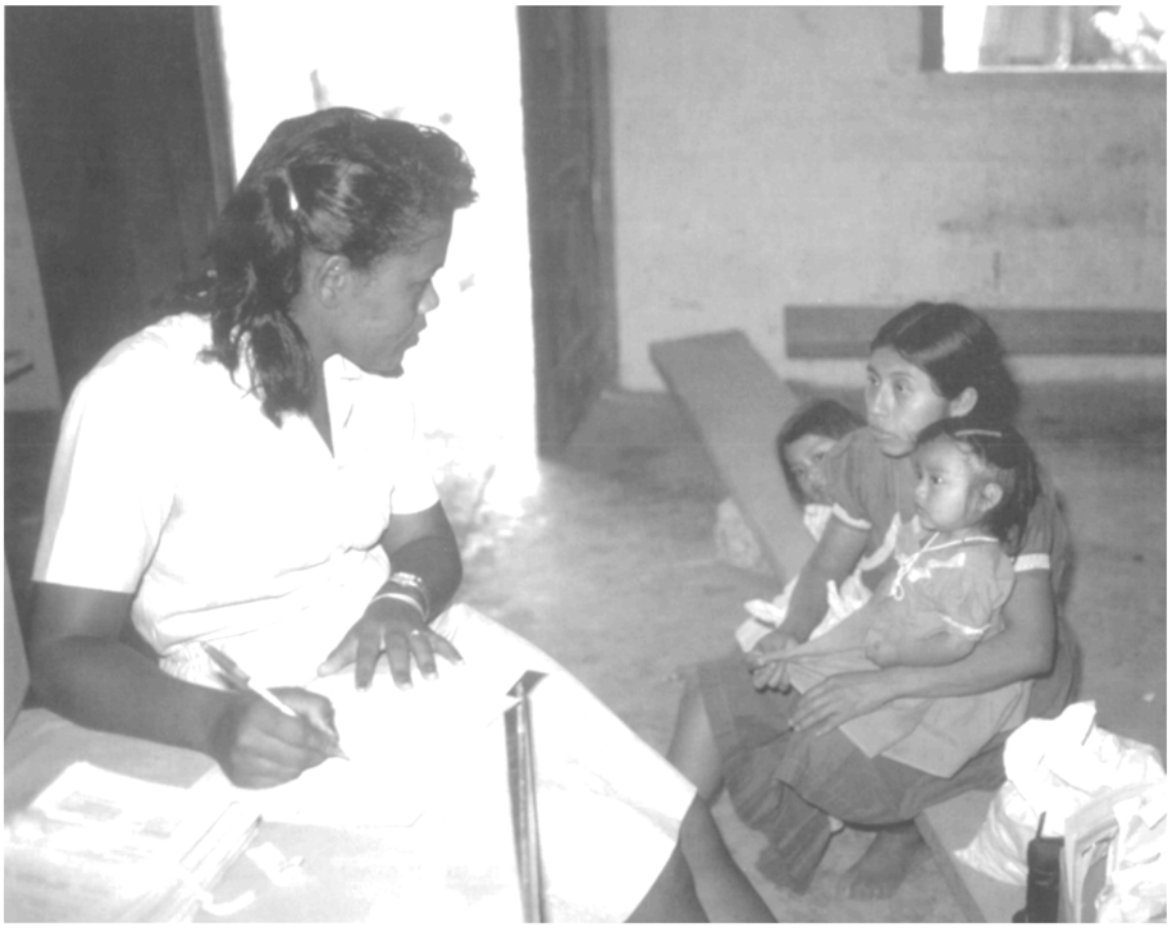
Overall, similar social equity issues arise as with cross-border and consumption abroad. In addition, Mode III raises the issue of host government incentives and other forms of subsidisation of foreign direct investment (FDI). Potentially positive impacts of FDI on the delivery of health services include:

- increasing resources for investment in and upgrading of health care infrastructure and infusion of new technologies and managerial skills;
- generating employment and reducing the unemployment of health personnel;
- reducing the factors that cause emigration (lack of training and skills upgrading, low wages, etc.;
- bringing expensive and specialised medical services that increase the quality, capacity, accessibility and productivity of health care;
- helping reduce the burden on government resources and helping to restore public health care.

Potentially negative impacts of Mode III on health services delivery may include:

- the use of huge public investment (to attract FDI);
- the creation of super-specialised corporate hospitals using public funds and subsidies that could go to the public health care system;
- a two-tier health care system – a corporatised high-end, high technology system catering to wealthy nationals and foreigners and a public low-end, resource-poor system for the poor;
- internal brain drain (as health care professionals cluster into the corporatised system, leaving the public system under-staffed);
- a health care delivery system that concentrates on high technology and not meeting the needs of poor or vulnerable groups;
- crowding out of poorer patients ('cream skimming'), i.e. those who need less but can pay more are served at the expense of the poor (observed in Latin America and possibly also occurring in Bangladesh and Thailand).

Gender equity issues in Mode IV include most of the aspects discussed under the other two modes of supply. However, a primary gender differentiated impact of commercial presence is in the area of employment. Typically, FDI has tended to rely on the absorption of female labour. Whether this trend will continue in the area of health care is not clear. The outcome will depend on the nature of the inflow of FDI in the sector – whether it increases the supply of primary care or is in the high tech end of the industry. Likely impacts are that low-level work in cleaning, catering, etc. will draw on female labour. Nurses and administrative staff may also be predominantly women. However, more technical and skilled staff may be male or female depending on the gendered patterns of higher and advanced medical education and training in the host country.



A health clinic in Belize

INTERNATIONAL FUND FOR AGRICULTURAL DEVELOPMENT IFAD)/F. MATTIOLI

***Box 4.7* The Extent of Movement of Health Personnel**

- 56 per cent of migrating physicians move from developing to developed countries.
- 55.6 per cent of pathology graduates in Ethiopia migrated from 1984–94.
- 60 per cent of Ghanaian doctors trained locally in the 1980s emigrated.
- Many African doctors migrate to Jamaica.
- Jamaica imports nurses from Ghana, Myanmar and Nigeria and exports nurses to Canada and the US.
- 50 per cent of registered nurses' posts and 30 per cent of posts for midwives were unfilled in Jamaica in 1995.
- Indian doctors emigrate to the Gulf States and the Middle East.
- The UK exports nurses to Canada and the US and imports nurses and doctors from India, Ireland and South Africa.
- South African doctors, nurses and technicians emigrate to Australia, the Middle East, the UK and the US.
- 10,000 health professionals emigrated from South Africa from 1989–97.
- Over 21,000 Nigerian doctors are practicing in the US.
- Of the 1,200 doctors trained in Zimbabwe in the 1990s, only 360 were practising in the country in 2001.
- About half of Pakistan's medical graduates leave the country in any year.

Mode IV: movement of natural persons

The movement of natural persons generally applies to the temporary movement of skilled personnel, in this case nurses, doctors, specialists, paramedics, midwives, technicians, consultants, trainers and administrators (see box 4.7). For example, the Caribbean (particularly Jamaica) sends nurses to Canada,

the UK, the US and elsewhere. In the meantime, nurses from lower wage countries such as Ghana are being imported into Jamaica to make up for the absence of locally trained nurses.

Social equity and gender issues

Overall, Mode IV is held to be potentially welfare-enhancing for health care professionals as it provides them with opportunities for higher wages, wider knowledge and skills and experience working in and with superior health care facilities. However, its impact on the national economy can potentially be disastrous (see box 4.8). Negative social equity issues in the sending country include a shortage of health care professionals (the brain drain), less access to care, a reduced range of services and lessened quality of health care.

Due to the increasingly flexible global labour market, there is an emerging health worker crisis in Africa that threatens to undermine health improvements made in that region.

Box 4.8 The Effect of the Movement of Natural Persons on National Economies

The 2002 joint consultative meeting organised by the WHO Regional Office for Africa (WHO/AFRO) and the World Bank noted that, due to the increasingly flexible global labour market, there is an emerging health worker crisis in Africa that threatens to undermine health improvements made in that region. The meeting included senior officials from Ministries of Health, Education, Labour, Planning and Finance from 17 African countries – Algeria, Angola, Cameroon, Chad, Côte d'Ivoire, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Niger, Nigeria, Senegal, South Africa, Tanzania, Uganda and Zimbabwe. Participants argued that factors such as "unsuitable training programmes . . . [in light of] . . . changing health conditions, inadequate co-operation . . . and loss of staff to opportunities outside Africa" were creating unsustainable problems of "lack of qualified motivated doctors, nurses and other health workers". It was further noted that there were "tens of thousands of African doctors and nurses outside Africa, and more leaving every day, making it increasingly difficult to furnish patient care in African countries".

Source: **WHO Press Release, 1 February 2002.**

While they may be making more money than they would in their home countries, nurses are still being marginalised in low-paid positions in countries with high costs of living and racism and sexism embedded into the culture.

This aspect of the supply of health services under the GATS is of particular importance to women. Women have a high dependence on health care services. They also constitute a large proportion of the flow of health care personnel. This is particularly so with regard to nursing personnel, who make up 70 per cent of health care staff and 80 per cent of direct patient care. The cross-border movement of nurses is significant for a number of reasons:

- women predominate in this job category;
- the nursing shortage has an impact on women patients in the sending economy;
- many countries are involved in the export and import of nurses;
- while they may be making more money than they would in their home countries, nurses are still being marginalised in low-paid positions in countries with high costs of living and racism and sexism embedded into the culture.

There are efforts underway to balance the personal welfare-enhancing elements of Mode IV with the responsibility of governments to provide health care for their populations in such a manner as to improve the population's health status and contribute to development. Among the first issue to be addressed is the targeted recruitment of skills. For example, Commonwealth Health Ministers have agreed to a voluntary Code of Practice for the International Recruitment of Health Workers. This fully recognises the rights of individuals to migrate and seeks to ensure they are not exploited. At the same time, the protocol addresses national requirements for sufficient human resources to meet the basic health needs of the population. Simultaneously, attention is being given to the 'push' factors, identified through research to determine factors contributing to the loss of needed skills.

Snapshots of country experiences with trade in health services

India

India is prominent in the export of health services (via Mode IV) to both developing and developed countries. Many Indian

doctors, nurses and technicians leave to work in Australia, Canada, the Middle East, the UK and the US. They may be either on short-term contracts or permanently emigrating. In many cases the training is subsidised by the government. However, this brain drain is not offset by a compensating inflow of foreign health service providers. In terms of consumption abroad, India is also strong in low cost and high quality treatment, via specialised corporate hospitals, in neurology, cardiology, endocrinology, nephrology and urology. In addition, India has a niche area in traditional medicines: Unani, Ayurvedic and homeopathic forms of treatment.

In terms of commercial presence, India now allows 100 per cent ownership of FDI in the health sector in some cases. Consequently, there is the trend for TNCs to invest in hospitals. Accompanying this have been some limited signs of a reversal of the brain drain. Other areas of the export of health service for India include medical studies, clinical trials and research, and telemedicine services.

Despite the tremendous growth in the Indian health service there are adverse impacts on the public health care system with significant social equity implications. These have been identified as including:

- benefits limited to the affluent urban population;
- catering to foreigners at the expense of local vulnerable populations;
- public hospitals remain substandard while private ones are of an international standard;
- internal brain drain;
- lack of access for the poor;
- commercial presence has not yielded benefits to the poor.

Bangladesh

Bangladesh imports health care from India (consumption abroad). It opened its hospital sector to FDI in 1999. Since then, an internal brain drain causing mal-distribution (urban *versus* rural, etc.) has been observed in the country.

Box 4.9 Typical Impediments to Health Services Trade

Overall, barriers to trade in health services (usually based on either public policy, protection or political economy justifications) include at least three broad categories:

1. *Restriction on entry and terms of practice for health service providers:* Generally effective on Mode IV and indirectly on III, these are: (a) border measures such as immigration regulations (quantitative limits on entry and eligibility conditions for entry); and (b) domestic regulations on cross-border mobility such as accreditation and licensing requirements, economic and local market needs tests and manpower-planning tests.
2. *Restriction on FDI in health and related sectors:* Foreign investment regulations include limits on equity participation; discriminatory taxes and other treatment; restrictive competition policies; economic needs tests; authorisation requirements and clearance from national ministries; and quantitative limits on the number, location, staffing and management of foreign establishments. Restrictive investment regulations in other areas such as insurance, education and telecommunications can also impact on FDI in health.
3. *Domestic infrastructural, regulatory and capacity constraints:* These are mainly deterrents, such as when a country does not have a well-developed regulatory and legal framework. There may be inadequate telecom facilities, low standards, low quality physical and human resources, a shortage of financial resources and a shortage of well-trained and skilled doctors, nurses, etc.

Other barriers to inflows of FDI include exchange controls (which impact on repatriation fees and expenses of commercial presence services providers and Mode IV) and discrimination against foreign health professionals (e.g. harsher working conditions).

United Kingdom

The UK has adopted a conscious policy of exporting health services. Since 1998, the UK's National Health services overseas enterprises has been marketing its public health companies abroad (Mode I). The UK also imports health services via Mode IV. There is a persistent shortage of general practitioners, nurses and technicians. In terms of consumption abroad, UK citizens seek lower cost or alternative treatment in developing countries such as India, as well as in Canada and the US.

Recommended strategies and measures

Strategies and measures to facilitate trade in health services that are beneficial to women and the poor would include:

For consumption abroad and commercial presence (Modes II/III):

- a regulatory framework to ensure that the benefits of upgrading are extended to all patients;
- well-enforced contractual agreements between government and private health care establishments to ensure access for those in need;
- system for transfer of resources and cross-subsidisation from the private to the public health care system;
- special provisions for the poor to obtain free or subsidised treatment.

For the movement of natural persons (Mode IV):[5]

- addressing the issue of better education and training for nurses and health care workers;
- rethinking and reformulating health sector reform measures in order to:
  a) remedy the structural and systemic difficulties created by previous reform measures;

5 Adapted from WHO/AFRO–World Bank Joint Consultative Meeting, Ethiopia, January 2002.

b) develop new pathways for enrolling prospective students (through consultation with and participation of doctors, nurses and health care professional associations);

c) devise better teaching curricula in the context of the promotion of better working conditions;

d) place focused attention on the problems faced by health care workers;

- looking for new opportunities within the context of the global economy in terms of new approaches to external/internal debt management that release domestic resources for the health sector;
- establishing country-specific benchmarks for fairness in health reform through dialogue and consultation with civil society and all stakeholders;
- developing policies and programmes to bridge the institutional barriers between sector ministries (health, education, labour, finance and trade) as well as between medical/training schools and these ministries.

Education[6]

Like health services, education is another important target for trade liberalisation. Public expenditure on education is about 6 per cent of GDP in OECD countries and 4 per cent in developing countries. The private education industry is around $100 billion in the US alone (WTO, 1998). Education is traded internationally through the four modes as follows:

- commercial presence: setting up educational institutions abroad;
- cross-border supply: distance learning;
- consumption abroad: student mobility across borders;
- presence of natural persons: teachers working abroad.

6 This section is mainly an adaptation of Riley (2002) and People & the Planet and Trade Justice Coalition (2001).

From a gender perspective, education "is the area of social development in which women and girls have made the greatest advances during the era of global conferences on women. However, women continue to have a lower literacy rate than men in many parts of the world and girl children's enrolment rate in primary schools is consistently lower than boys' in many developing countries. The gap between girls' and boys' enrolment rates increases as the school level advances. There are some outstanding exceptions to this trend, such as in many Caribbean countries, where there is an on-going commitment to universal education. However, the exception is not the rule for women and girls in many developing countries" (Riley, 2002).

Education is one of the sectors that have experienced rapid and tumultuous changes in developing countries over the last twenty years. SAPs in many countries led to a reduction in access to and availability of schools, overcrowding and a decline in the quality of services. Although there is now a strong push to turn around this trend and regain new footing, the net result has been reduced educational opportunities for girls and boys. A case in point is Senegal, where reductions in budget allocations to education led to the introduction of a system whereby teachers have to teach up to one hundred students in two shifts (Fall, 1999). This practice has led to overwork and exhaustion. Though discontinued in wealthy areas, it is still widespread in poor and rural communities.

SAPs in many countries led to a reduction in access to and availability of schools, overcrowding and a decline in the quality of services . . . [T]he net result has been reduced educational opportunities for girls and boys.

Educational challenges in the South

The implementation of GATS and the expansion of commitments in the educational sector are likely to exacerbate negative trends in education. These include:

- diminishing the role of the state/decentralisation of education systems through:
  a) shifting the financing responsibility from national budgets to household budgets;
  b) privatisation of the educational system;
  c) imposing community-based and user fee systems for primary education;

- inadequate resources for universal primary education;
- insignificant movement towards universal secondary education;
- rising costs of private education.

Already GATS Article VI on Domestic Regulations "takes a minimalist view on the kinds of regulations that should govern services, including education" (Riley, 2002). Article VI 4 states that disciplines relating to qualifications, procedures, licensing and technical standards should be no more "burdensome than necessary to ensure the quality of the service". However, 'the quality of the service' does not address the critical question of distribution of services that leaves populations in poverty.

Box 4.10 Barriers to trade in education

Barriers to trade in education include:

- **restricting the mobility of students;**
- **restrictions on the translation of foreign degrees and qualifications;**
- **nationality requirements;**
- **the existence of government monopolies and high subsidisation of local institutions;**
- **inability to obtain national licenses;**
- **measures limiting direct investment by foreign education providers;**
- **needs tests and restrictions on recruiting foreign teachers.**

Source: **People & the Planet and Trade Justice Coalition, 2001**

In the debate about what services sectors are exempt under GATS, the educational sector is highly contentious since in most countries it has private and public, commercial and non-

commercial aspects. This has been further fuelled by SAPs. Since education is often supplied on a commercial basis and in competition with other private sector services providers, it is ripe for liberalisation. There is likely to be a chilling effect on governments' ability and willingness to subsidise and regulate public education. A clear example of this is Zambia's decision to shift education costs to local communities and families. A recent study has shown that this programme has had a significant impact on the quality of basic education and has contributed significantly to a decline in enrolment and retention rates. The percentage decline in enrolment of girls is almost twice that of boys.

Tourism

International tourism is increasingly becoming a significant part of global trade. It is one of the top five export categories for about 83 per cent of countries in the world. The South's share is about one-third of the total, and tourism is a fundamental source of income and foreign exchange for a number of developing countries. Tourism is lauded for having a higher positive multiplier spill-over effect than most economic sectors. It is widely claimed that for each job created in tourism there are nine jobs generated in other areas. To date it is the only sector in the services area where developing countries have consistent surpluses.

It is widely claimed that for each job created in tourism there are nine jobs generated in other areas. To date it is the only sector in the services area where developing countries have consistent surpluses.

Tourism is linked to other areas of the economy such as agriculture, land and labour. It is also inextricably intertwined with air transportation, the major means used by tourists arriving in the South (a US$414 trillion industry) and communication. Given this, the liberalisation of tourism has major implications for social development and gender equality.

The GATS regulates tourism via rules on the production, distribution and marketing of tourism services. Under the four modes or methods of supply, it covers:

- commercial presence: international hotel chains, branches or full ownership of hotel chains and agencies in other countries;
- cross-border supply: tour operators supplying services in other countries;

- consumption abroad: international visitors;
- presence of natural persons: the activities of tour guides and hotel managers.

The direct impacts of the GATS as it relates to tourism could include:

- facilitating foreign companies to merge with or take over local companies, which is a threat to indigenous-owned and operated sustainable tourism initiatives;
- putting upward pressure on the exchange rate with implications for real wages, the price of land and other resources as well as for traditional exports such as agriculture, mining and fishing;
- having a potentially detrimental effect on eco and heritage tourism development;
- having serious implications for national tourism measures that attempt to generate net benefits to the poor (i.e. instead of promoting more foreign investment into the sector, the government promotes the development of local community ownership of tourism services in terms of historical or cultural tourism, or local bed and breakfast type arrangements);
- affecting governments' use of taxation policies to support industry and agriculture through domestic regulation rules;
- limiting governments' ability to mitigate the impact of the outflow of repatriated earnings from FDI, which will result in reduced welfare.

Gender and tourism

The issue of tourism, development and gender equality is multi-dimensional. It includes:

- the low profile and persistent issue of the lopsided division of responsibility for social reproduction and community resource management between men and women;
- the differential and gender-based nature and consequences of access to social and economic resources;

- the pervasive reliance on (and at the same time the invisibility of) women's labour in the hospitality sector;
- the high profile issues of sex tourism and HIV/AIDS.

Both women and men at all levels of society are affected to different degrees by tourism and tourism development. Men in poorer classes may suffer similarly to poor women from the welfare-reducing impact of loss of access to resources. However, there are significant gender biases and inequalities in terms of access to employment and physical and social resources that mean women have greater vulnerabilities and constraints in enjoying the presumed benefits of tourism development.

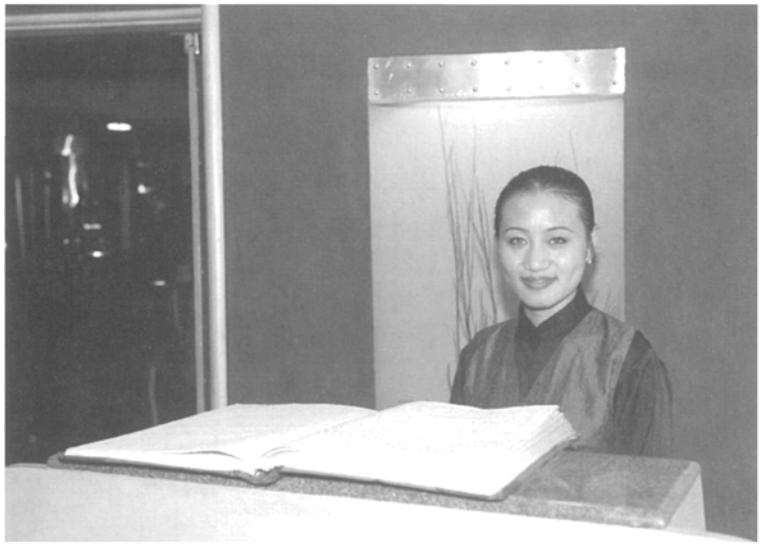
These impacts take place across five categories: (1) formal sector employment; (2) informal sector activities and sustainable livelihoods; (3) women's social and economic status and empowerment; (4) sex tourism; and (5) women's influence and decision-making around tourism development policy.

There are significant gender biases and inequalities in terms of access to employment and physical and social resources that mean women have greater vulnerabilities and constraints in enjoying the presumed benefits of tourism development.

1. Formal sector employment

Like all other forms of employment, access to tourism-related employment is gender biased. Due to gender stereotyping, men and women are segregated into different occupations. Women are seen as cheaper labour than men, who tend to predominate in the formal sector of the tourism industry. In India, women make up a small percentage of the employed (2.98%) while in Sri Lanka it is somewhat higher (14.9%). In the Caribbean and Latin America the percentage is significantly higher (35%) (Badger, 1993).

Even where women are the main tourism workers, however, they tend to be found most often in menial, semi-skilled, domestic and service-type occupations. In Barbados and Jamaica, for example, women are employed in less stable, lower status work such as housekeeping, reception and other services. Due to lack of unionisation, these jobs require low skills, are poorly paid and have the least security of tenure and benefits. While men are often employed as stewards and porters, they tend to be over-represented in professional, managerial and supervisory positions. A recent survey of the literature on women and tourism points out that in the food sector "women are at the bottom of the hierarchy as restaurant helpers, cooks (not chefs) and waitresses – all the lowest paid parts . . . Chefs



The receptionist at the Octopus bar in the World Habitat complex, New Delhi, India

INTERNATIONAL LABOUR ORGANIZATION/ M. CROZET

in fancier restaurants where salaries and tips are substantial are more likely to be males" (Equations, 2000). Similarly, in the travel sector women are more often found in seasonal, part-time or minimum wage jobs. They "tend to dominate small travel agencies and the majority are travel agents but men control the major sectors: airlines, railroads, hotel chains, car rental companies [and] travel magazines" (Equations, 2000).

Given the conditions of work, generally low pay, lack of benefits and the absence of human resource development, serious concerns arise about women's longer-term prosperity. Although increased tourism may mean more jobs for women, questions must be raised about the nature, quality and type of work activities available and the differential access of men and women to such opportunities.

2. Informal sector activities and sustainable livelihoods

Gender hierarchies also exist in the informal sector, where women predominate. They provide a wide range of services to tourists, including washing clothes, petty trading, cooking and childcare. Women are often involved in the production of local handicrafts and the marketing of such items while men provide services and support for women's home craft production. In some cases, women produce the works and sell them in local markets while men control the wholesaling in urban centres.

Overall, some women in some countries may gain financial autonomy and a measure of economic independence from their participation in informal markets linked to the tourism trade. In an Equations survey, cases from China, Mexico and Panama are presented as examples of such gains. However, some of the same researchers also noted that women appear to be invisible and neglected in cultural and historical attractions, though they may figure prominently in advertising, post cards and souvenirs (Equations, 2000).

Although increased tourism may mean more jobs for women, questions must be raised about the nature, quality and type of work activities available.

3. Women's social and economic status and empowerment

Women's social and economic status and overall economic empowerment are influenced by their status and role in the family and community, their social reproduction responsibilities (as purveyors of food and essential services) and their access, ownership and control over resources. Tourism impacts greatly on all of these, negatively or positively. In terms of family and community life, tourism can either bring greater access to basic services (roads, water, electricity and sanitation) or it may reduce such access if services are diverted to hotels and resorts or there are restrictions on access to local resources due to tourism development.

In Western Samoa, for example, it is reported that tourism has led to the commoditisation of traditional beliefs and practices and undermined traditional customs that gave specific, well-defined rights and resources to men and women. Through its direct impact on local prices (land and food) as well as its indirect impact via changes in the exchange rate, tourism can add to women's social reproduction burden. It certainly will affect their access to and ownership of economic resources. Furthermore, if tourism development is promoted via tax breaks for hotels and the construction of tourist attractions, this will divert resources from the social budget with negative implications for social services. All of these have adverse impacts on women's daily lives, work activities, food and nutritional status, and access to education and health care. Thus women often pay the cost of tourism disproportionately while reaping few of the benefits (Fillmore, 2000).

On the positive side, increased employment in tourism can enhance women's financial and economic autonomy. Likewise, additional government revenue from the tourist sector may

Governments should take proactive measures to promote better jobs and working conditions at all levels of the tourism sector. Special policies are also needed to promote women's involvement at the higher and more lucrative levels.

make more money available for the promotion of social development. Much therefore depends on a government's ability and willingness to use fiscal and monetary measures to ensure that there is social development linked to increased tourism development. Governments should take proactive measures to promote better jobs and working conditions at all levels of the tourism sector. Special policies are also needed to promote women's involvement at the higher and more lucrative levels. Whether such actions are possible and chosen by economic decision-makers will depend on two main factors: (i) the opportunities and constraints built into the multilateral trading system (MTS) that now governs tourism; and (ii) the activism of women and other social activists to influence governments to work in the interest of gender equity and human development.

4. Sex tourism

Women are often exploited in the marketing of tourism due to existing gender perceptions and stereotypes that dominate social relations in the host and sending countries. As seen above, even in the formal labour markets there is a manipulation of the sexual division of labour that shunts women to the lowest paid jobs. Likewise, there is much manipulation of gender differences in order to "feed the fantasy of the male tourist" (Badger, 1993). Very often this occurs at the benign level of women being offered opportunities in frontline (hospitality) positions. Such opportunities are linked to women's presumed feminine qualities of being more sociable and more hospitable than men. Increasingly, however, women are directly exploited as sexual playthings and earners of foreign exchange in prostitution and sex tourism. Many women are forced to take up this work because of poverty and lack of access to other options; others are trafficked against their will. In either case, they are exposed to tremendous health hazards and gender-based violence.

Sex tourism has been raised as a key issue in the appeal of South-East Asian destinations. This is particularly the case in Cambodia and Thailand where there is an influx of young girls from Burma, China, Indonesia and Laos to work in bars and brothels. Children are often bought and sold like cattle in Bangkok or the beach resorts and there is an active slave trade

in young sex workers (New Frontiers, 2001). Many vulnerable women and young girls start as housekeepers, go on to work in *karaoke* bars or nightclubs and then are forced into sex work. Sex tourism is also an enduring feature of Caribbean tourism. While in some cases, such as the gay and paedophilia markets, the customers are exclusively male, there is high incidence here of female customers patronising male sex suppliers.

Increasingly ... women are directly exploited as sexual playthings and earners of foreign exchange in prostitution and sex tourism.

5. Influence, power and decision-making

In general, the political and economic fora that structure and drive tourism policy and tourism development are dominated by male economic agents. Few women get to play an active role in shaping tourism policy and practice at an official level. Increasingly, however, women in their many roles are finding ways to have an active voice. The struggle over the nature, extent and pace of further liberalisation in this and other sectors on the WTO agenda is now on-going. This arena provides a good space for women's activism on these issues locally, nationally, regionally and globally.

Pointers for Further Discussion

Apart from agricultural liberalisation and the AOA, it is quite likely that trade liberalisation of services and the GATS have the most powerful and direct impact on the lives of women and men in developing countries. They raise a large question about the long-term possibilities for women and men to grow and evolve as contributors to their nation and society as whole. As should be clear from this very preliminary approach to casting a gender lens on services, the terrain is vast and complicated. A lot of uncertainties exist about the nature and scope of services liberalisation – including where it will all eventually end, who it will benefit and who will be most disadvantaged.

This has been a first attempt to articulate the key concepts, policy challenges and possible impacts on social and gender relations of a few of the different sub-sectors in services. The questions in box 4.11 and the recommendations section of Chapter 7 provide additional ideas and directions for future policy-oriented research and interventions in this area.

Box 4.11 Key Questions on Gender and Trade in Services

1. What is the extent of liberalisation of trade in the different sub-sectors of the services sector – education, health, tourism, water, sanitation, electrification – that has occurred in developing countries?
2. What factors are typical attractions or impediments to trade in the different sub-sectors and what are their gender dimensions?
3. What are emerging forms of health services and what are their gender dimensions?
4. What are the national and local trade-offs between social and development objectives and commercial/liberalisation of trade in services? What are the gender dimensions of these trade-offs? What supporting or offsetting programmes and policies might be needed to mitigate the most negative effects?
5. What kinds of supporting policies are needed to ensure trade in the different sub-sectors does not occur at the expense of national priorities and the interests of the poor – especially poor women – under SAPs, under GATS and under regional arrangements?
6. What is the nature of the substitution of private for public funds and services, private-public partnerships (or private finance initiatives) and private sector accounting rules to public services? What threat does this pose to universal coverage, solidarity through risk pooling, equity and comprehensive care?

Adapted from Price *et al.* (1999)