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HEALTH SERVICES AS SERVICES SUPPLIED IN THE EXERCISE OF GOVERNMENTAL AUTHORITY UNDER GATS ARTICLE I:3(C): LEGAL DESIGN CHOICES FOR UZBEKISTAN BASED ON COMPARATIVE LEGISLATIVE EXPERIENCE

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Abstract

This article analyses how Uzbekistan can structure its health system so that a clearly defined core package of health services qualifies as "services supplied in the exercise of governmental authority" under GATS Article I:3(c). Since this provision applies only to services supplied neither on a commercial basis nor in competition, the legal status of health services depends primarily on domestic legislative and institutional design rather than on ownership alone. Focusing on Uzbekistan's ongoing health reforms and WTO accession ambitions, the article proposes concrete statutory design choices, including the establishment of a State-Guaranteed Health Services regime, a strict free-entitlement rule, public-mandate contracting with regulated tariffs, and legally enforceable separation between guaranteed and paid services. Drawing on comparative experience from the United Kingdom, the European Union, Thailand, and Estonia, it argues that embedding these techniques in national law can preserve policy space for core public health services while ensuring their defensibility under GATS Article I:3(c).

Keywords: GATS Article I:3(c); health services; governmental authority; Uzbekistan; WTO accession; legal design.

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Introduction

Health Services, Trade Law, and the Need for a Legally Robust Governmental Authority Regime. The regulation of health services increasingly intersects with international trade law, particularly with the General Agreement on Trade in Services (GATS), which establishes a multilateral legal framework for the liberalisation and regulation of trade in services while simultaneously preserving a specific carve-out for "services supplied in the exercise of governmental authority" under Article I:3(c).[1] This provision, which defines such services as those supplied neither on a commercial basis nor in competition with one or more service suppliers, is of fundamental importance for states that seek to constitutionally entrench health care as a core public function rather than as a market commodity, yet its practical legal effect depends not on political declarations but on the concrete legislative and institutional design of national health systems.[2] In mixed systems, where public and private providers coexist and where financing is drawn from both public and private sources, the legal characterisation of health services under GATS becomes particularly sensitive, because the presence of user charges, market-based pricing, advertising, or provider competition can weaken the claim that a service is genuinely non-commercial and non-competitive.[3] Uzbekistan is currently undertaking profound reforms in health financing, primary health care, digital health governance, and national health insurance, and this transformation coincides with the country's strategic objective of deeper integration into the multilateral trading system, including eventual accession to the World Trade Organization, which makes it legally necessary to ensure that the core architecture of the health system is compatible with, and defensible under, GATS disciplines.[4] The central legal question is therefore not whether health services should be "public" or "private" in an abstract sense, but how domestic legislation should be structured so that a clearly defined State-Guaranteed Health Services regime can credibly qualify as "services supplied in the exercise of

[1] World Trade Organization, General Agreement on Trade in Services (1994) art I:3(c).
[2] World Trade Organization, WTO Analytical Index: GATS – Article I (Scope and Definition) (WTO, latest edn).
[3] World Health Organization and World Trade Organization, WTO Agreements and Public Health: A Joint Study by the WHO and the WTO Secretariat (WHO/WTO 2002).
[4] World Trade Organization, 'Accession to the WTO: A Handbook for Policymakers and Practitioners' (WTO 2015).

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governmental authority" within the meaning of Article I:3(c),[5] while allowing supplementary and ancillary services to operate under regulated market conditions without undermining the legal status of the public core. Comparative experience from jurisdictions such as the United Kingdom, the European Union, Thailand, and Estonia demonstrates that successful protection of public health services under trade law is not achieved through broad political reservations alone but through precise statutory definitions, enforceable free-entitlement rules, public-mandate contracting mechanisms, strict separation between public and paid services, and legally binding digital and regulatory infrastructures, all of which together ensure that publicly funded or state-supported health services are structurally insulated from commercial logic and competitive market dynamics.[6] For Uzbekistan, the reform moment creates a unique opportunity to embed these legal techniques directly into national legislation, thereby strengthening both the internal coherence of the health system and the external defensibility of its core services under GATS Article I:3(c), and this article therefore proposes a set of concrete legislative design choices, grounded in comparative legal experience, aimed at transforming the current reform trajectory into a legally robust governmental authority regime for health services.

II. Health Services as Services Supplied in the Exercise of Governmental Authority under GATS Article I:3(c). The General Agreement on Trade in Services establishes a comprehensive framework for the liberalisation and regulation of international trade in services, yet it simultaneously recognises that certain services occupy a special constitutional position within the state and therefore fall outside the scope of market disciplines, and Article I:3(c) gives legal expression to this by defining "services supplied in the exercise of governmental authority" as those which are supplied neither on a commercial basis nor in competition with one or more service suppliers, thereby creating a

[5] Peter Van den Bossche and Werner Zdouc, *The Law and Policy of the World Trade Organization: Text, Cases and Materials* (3rd edn, CUP 2013) 338–339.
[6] European Commission, 'Trade in Services and Public Services: The EU Approach' (Commission Staff Working Document, 2015).

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cumulative and functional test rather than a formal one based on ownership alone.[7] This distinction is decisive for health services because in most contemporary systems publicly owned hospitals may charge fees, compete with private clinics, advertise services, or cross-subsidise activities, while privately owned providers may act as mere contractors implementing public entitlements under strict regulatory control, which means that the legal character of a service under GATS depends on how the system is structured rather than on who owns the provider.[8] From a legal-technical perspective, a state that wishes to rely on Article I:3(c) must therefore design its health system so that the core package of services is structurally insulated from both commercial pricing and competitive market allocation, using public financing or mandatory insurance, unified benefit packages, regulated tariffs, administrative entitlement rules, and public-mandate delivery mechanisms instead of price signals, marketing, and consumer choice driven by market competition.[9] If such a design is achieved, the core services can credibly be characterised as governmental authority services excluded from GATS market access and national treatment disciplines, even though ancillary, supplementary, or elective health-related services may remain subject to trade and investment rules under carefully controlled conditions.[10] This approach is consistent with the object and purpose of the carve-out, which is not to freeze health systems in a purely statist model, but to preserve the legal space for states to organise essential social services as public functions while allowing selective and regulated openness in peripheral segments, and it follows that the decisive legal task for Uzbekistan is to translate this conceptual distinction into binding statutory categories, enforceable financing and charging rules, and mandatory institutional separations that prevent the gradual re-characterisation of core public services as commercial or competitive in fact, which would otherwise undermine the applicability of Article I:3(c) regardless of political intent.[11]

[7] World Trade Organization, General Agreement on Trade in Services (1994) art I:3(b)–(c).
[8] Rudolf Adlung, 'Public Services and the GATS' (WTO Staff Working Paper ERSD-2009-06, WTO 2009).
[9] OECD, The General Agreement on Trade in Services (GATS): A Review of the Current Situation (OECD 2002).
[10] Bernard Hoekman and Aaditya Mattoo, 'Services Trade and Growth' (2008) 17 World Bank Research Observer 1.
[11] WTO Secretariat, GATS Fact and Fiction (WTO Information Note).

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III. Legislative Proposals for Uzbekistan: Statutory Entrenchment of Non-Commercial and Non-Competitive Health Services. The first and most important legislative step for Uzbekistan is to amend the Law "On the Protection of the Health of Citizens" to introduce a legally distinct category of "State-Guaranteed Health Services" defined as a set of medical services and medicines financed from the state budget and/or mandatory health insurance funds, delivered under a public mandate, at regulated tariffs, and not offered on profit-seeking or competitive market terms, and to attach to this definition explicit legal consequences that mirror the two limbs of GATS Article I:3(c), namely non-commerciality and non-competition.[12] This requires, first, a statutory "free entitlement unless authorised by law" rule, modelled on the technique used in the United Kingdom's NHS legislation, under which beneficiaries of the Guaranteed Package may not be charged user fees, co-payments, or service charges except where Parliament itself has expressly authorised such charges in primary legislation subject to a public interest and proportionality test, thereby preventing executive or provider-level drift into ad hoc commercialisation that would legally re-characterise the service as supplied on a commercial basis.[13] Second, it requires a statutory public-mandate contracting regime under which both state and non-state providers may participate in delivering Guaranteed Package services only through standardised contracts awarded by the national health insurance fund or equivalent public purchaser, with regulated tariffs, mandatory clinical protocols, audit rights, and sanctions, and with an explicit prohibition on marketing or advertising Guaranteed Package entitlements as a competitive advantage, so that providers are legally positioned as delegates of a public function rather than as competitors in a market.[14] Third, it requires legally binding "firewalls" inside provider organisations that offer both Guaranteed Package and paid services, including mandatory separate accounting, cost allocation rules, separate patient pathways and booking systems, prohibitions on cross-subsidisation, independent audit obligations, and administrative liability

[12] Republic of Uzbekistan, Law No 265-I 'On the Protection of the Health of Citizens' (29 August 1996, as amended).
[13] National Health Service Act 2006 (UK); UK Department of Health and Social Care, The NHS Constitution for England.
[14] World Health Organization, Strategic Purchasing for Universal Health Coverage: Key Policy Issues and Questions (WHO 2019).

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for coercing or steering patients into paid pathways when they are entitled to public services, because without such statutory separations the factual conditions of competition and commerciality will inevitably arise and weaken the legal status of the public package under Article I:3(c).[15] Fourth, the law should establish a statutory ban on price advertising and competitive marketing for Guaranteed Package services, while permitting regulator-mandated publication of quality and performance indicators as a transparency and accountability tool rather than as a market signal, thereby reinforcing the non-competitive character of public service delivery. Fifth, Parliament should elevate the legal status of the national health insurance fund's purchasing powers and duties by defining in statute its competence to administer entitlements, conclude and enforce public-mandate contracts, set and publish tariffs, conduct audits, and combat fraud, and by making provider participation in the Guaranteed Package conditional on acceptance of these statutory controls, which reflects the purchaser–provider split model successfully used in Thailand's universal coverage system to preserve the public entitlement character of services even where non-state providers are involved.[16] Finally, the amended law should include an interpretive clause stating that the Guaranteed Package constitutes a regime of services supplied in the exercise of governmental authority, not supplied on a commercial basis and not in competition, and that participation of non-state providers occurs solely as a delegation of a public mandate under regulated conditions, which, taken together with the concrete charging, contracting, and firewall rules, creates a legally robust domestic foundation for invoking GATS Article I:3(c) in good faith.[17]

IV. Comparative Legislative Techniques and Cross-Border Dimensions: Making the Uzbek Health System GATS-Resilient. Comparative experience shows that successful protection of public health services under trade and investment law is achieved not by abstract declarations but by a consistent set of

[15] OECD, Competition and Regulation in Public Services (OECD 2011).
[16] Viroj Tangcharoensathien et al, 'Achieving Universal Health Coverage in Thailand: What Lessons Can Be Learned?' (2018) 392 The Lancet 1167.
[17] World Trade Organization, WTO Analytical Index: GATS – Article I (on governmental authority services).

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legal techniques that structurally distinguish publicly funded or state-supported services from market services, and the practice of the European Union and the United Kingdom in trade agreements demonstrates the effectiveness of defining a broad category of health services that receive public funding or state support in any form and reserving full regulatory discretion over that category while subjecting only privately funded segments to market access disciplines.[18] Uzbekistan can internalise this technique in domestic law by defining "public funding or state support" broadly to include budget allocations, mandatory insurance contributions, reimbursements, state-funded infrastructure, preferential tax treatment linked to Guaranteed Package delivery, and state-guaranteed procurement, and by attaching to this definition the legal consequence that services delivered within this framework fall under the public-mandate regime and cannot be treated as privately funded market services. At the same time, legislation should address the GATS modes of supply problem by requiring establishment and local licensing for any entity providing clinical diagnosis or treatment to patients located in Uzbekistan, including via digital means, unless operating under a narrowly defined and supervised pilot framework, while allowing non-clinical support services such as medical IT or consultancy to be treated differently, thereby reflecting the EU and UK technique of conditioning health service supply on establishment and regulatory oversight.[19] In parallel, Uzbekistan should follow the Estonian model of legally mandating participation in the national e-health system by requiring all Guaranteed Package providers to use electronic records, e-prescriptions, referral systems, and digital claims submission as a condition of licensing and contracting, and by linking all public payments to compliant digital documentation, with administrative and contractual sanctions for non-compliance and fraud, thus transforming digital governance from a policy preference into enforceable legal infrastructure that protects entitlements and public funds.[20] Finally, to ensure long-term coherence between domestic law and

[18] Government of Canada, CETA Annex II (EU Party): Reservations for Health Services (official text); UK Government, UK–New Zealand FTA, Annex II.
[19] European Commission, Trade in Services Agreements and Public Services (2016).
[20] European Commission, 'Overview of National Laws on Electronic Health Records: Estonia' (2014).

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international obligations, Parliament should embed in the health legislation a general clause affirming the state's right to adopt or maintain measures necessary to protect public health, ensure equitable access, and preserve the integrity of publicly funded or state-supported health services, including through charging rules, contracting regimes, licensing requirements, and digital governance, in a manner consistent with GATS Article I:3(c), thereby adopting in domestic law the same structural logic that advanced jurisdictions use in their treaty reservations and internal statutes.[21] Taken together, these legislative techniques would not only strengthen Uzbekistan's ability to defend its core health services as governmental authority services under GATS, but would also improve legal certainty, accountability, and equity within the health system itself, demonstrating that trade law compatibility and strong public health governance are not competing objectives but mutually reinforcing outcomes of sound legislative design.

[21] World Health Organization, Health Systems Governance for Universal Health Coverage (WHO 2014).