Trade protocols and Health: Issues for Health Equity in Southern Africa

Southern and Eastern African Trade and Information Negotiations Initiative (SEATINI)
and
Southern African Regional Network for Equity in Health (EQUINET)

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Executive Summary

SADC countries have to face a wide variety of challenges to improve the health of her people. This paper discusses the challenges posed by global trade under the World Trade Organisation, particularly through the agreements that more directly impact on health (including GATS and TRIPS). It highlights the responses to these challenges in Africa and their strengths and weaknesses, both in historical practice and in new policy developments such as NEPAD.

The paper demonstrates the significant challenges that global trade and investment policies can and will have on health. It warns that to tap any opportunities from these agreements, countries need to be in a stronger position to protect national policy interests that are fundamental to equitable and sustainable development.

This paper supports the thrust towards strengthened regional integration as a means to confronting these global trade and investment challenges, while also calling for more equity within the regional integration process. This is suggested to be necessary to share capacities, information and resources in the region and to build the market size, resource base, production systems and regional trade necessary for the more internally driven development, growth and trade path that will meet longer term development and health goals. At the same time it presents information that indicates that while regional integration is a policy goal, intra-regional trade is still highly unequal and skewed towards a minority of stronger economies in the region.

Despite these challenges, SADC countries have a range of options that they can pursue to promote health, health care, health equity and efficient use of resources. The authors argue that southern Africans need to ensure that a wide variety of policy tools and options are available to our governments (as opposed to permanently giving up the right to these policy instruments), to increase the impact of their interventions. Parliaments can also ensure that the legislative frameworks provide for these policy tools, and provide voice and oversight to support such processes.

Challenge	Opportunity and Action
Make TNC's more accountable	Create standards for private conduct by regulating essential health and health related services.
Ensure policy flexibility for sovereign states to regulate in the interests of promoting and safeguarding public health.	Review international agreements that encroach and limit governments ability to promote and safeguard public health. From the review, seek to backtrack on commit-ments that limit government flexibility in key areas. **Action:** Consider policy options that have been made illegal through the trading system and their potential impact on increasing sustainable service delivery by consulting members international trade departments.

Challenge	Opportunity and Action
	Prevent/reduce further international trade commitments that will limit policy flexibility, specifically: New or further GATS commitments and Agreements on the "New Issues" – Competition, Transparency in Government Procurement, Trade Facilitation and Investment. **Action:** Consult and make input on governmental negotiating positions as regards public health and interdependent disciplines.
	Use the maximum amount of flexibility granted in international agreements to promote and safeguard public health interests. **Action:** Legislate and use the maximum allowable exceptions under the TRIPs agreement. Promote the right to sovereign domestic regulation. Consult and make input governmental negotiating positions
	Play a role in bilateral agreements between countries and international financial institutions (WB/IMF) agreements that seek to limit policy flexibility or extend obligations. **Action:** Consult Departments of Finance on conditionalities attached to loans.
Develop agriculture for food sovereignty	Seek greater market access and better prices for produce. **Action:** Liaise with Departments of Agriculture and International trade and make inputs that promote food sovereignty. Seek the elimination of agricultural subsidies and resist the demand for a reduction in agricultural tariffs. Promote sustainable agriculture to support the nutritional needs of citizens.
Promote the development of regional standards	Develop regional standards and disciplines to reduce the barriers to internal trade and regional dependency. **Action:** Establish and support local SPS and standards generating bodies.
TRIPs	Protect indigenous knowledge systems by implementing independent protection for plant varieties. Promote public health by using the TRIPs flexibilities by passing legislation that allows compulsory licensing, domestic production and parallel importation of drugs to ensure adequate access to drugs. **Action:** Legislate independent intellectual property rights regimes and rights provided in TRIPS flexibilities
	Regulate the research and development of essential drugs for addressing regional disease burdens. **Action:** Regulate and direct research priorities.
	Seek a declaration from the WTO Ministerial conferences that prevents the patenting of life forms. Consult and make input on governmental negotiating positions
GATS	
Regulation of trade in essential services like health, water, electricity etc	Ensure that member states ability to regulate and provide essential public services. **Action:** Avoid making commitments in essential services and reverse/ restrict current commitments.
Disciplines on	The administrative burden to ensure health services are

Challenge	Opportunity and Action
transparency	transparent to domestic and foreign stakeholders may be time consuming and costly. **Action:** Transparency should be reasonably provided within country capacities to prevent resource diversion.
Promoting equity	Economic needs tests, monopolies and exclusive service providers are an effective way of promoting pro-equity goals and policy flexibility should be retained.
NEPAD	Interrogate and engage with NEPAD health action plan to identify areas of co-operation and potential collaboration. Advocate and promote regional interests and priorities. Promote complementary regional trade efforts through other regional structures. Enhance member states bargaining strengths in all fora by co-operating in negotiations on common interest issues.
New Issues	Refuse to make commitments on competition, government procurement, trade facilitation and investment.
Promotion of equity guided policies	Implement • The Abuja and SADC stipulated 12,5% minimum budget distribution to health • Capacity building member states to sustain health systems, particularly through public providers • Health-trade networking and joint reporting on impacts of trade agreements • Promotion of vertical equity in resource allocation • Effective state organisation and regulation to ensure an equitable public-private mix • Legal provisions to secure national authority in areas of public good and public health • Application of public health principles in adjudicating trade impacts

The paper calls for these policy tools to be backed by regional co-operation in global negotiations, in capacity support and in information sharing and for regional co-operation in strengthening parliamentary representative, oversight and legislative roles in these areas.

The bottom line is that the deep economic, social and political inequities that underlie inequities in health are driven by a global trade and investment system that operates in the self interest of wealthy countries. While it is becoming increasingly clear that such economic, trade and social inequities are not in the long term interests even of the wealthy, the commitment to addressing them is still extremely weak, particularly within trade systems. If we are to have a sustainable impact on health equity, we cannot rely on benevolence. It is rather the strength, direction and unity of our own actions that will secure our rights to development.

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1. BACKGROUND

Today's globalization has been criticised for being driven by the mechanisms, standards, rules and institutions for expanding markets and the movement of capital across the world, outpacing the policies, rules and institutions for protection of people and their rights. Poor communities, poor countries, and areas of human development provided outside markets, such as education and health, have suffered in this rather ruthless drive towards satisfying the profit motives of the biggest players in the market.

Southern African countries developing equity-oriented policies face significant external pressures. Globalisation has deepened the liberalisation trends initiated by the structural adjustment programmes. It has driven by market expansion, forcing open national borders to trade, capital and information. The principal channels for the transmission of these changes were the Bretton Woods institutions and the Uruguay Round of GATT that gave birth to the World Trade Organisation (WTO).

The changing trade environment poses enormous challenges to southern African countries. The trade negotiations at Uruguay extended the concept of trade liberalisation to significant new areas, including trade in services, trade related investments and intellectual property rights. The Uruguay round created a powerful enforcement mechanism, the Dispute Settlement Body, that can authorise a country to impose sanctions against a member who fails to honour its commitments. This enforcement mechanism favours the richer countries. These “multilateral agreements” have been backed by strong enforcement mechanisms that are not only binding on national governments but drastically reduce their scope for making policy. The policies of countries at various levels of development have differing priorities, a factor that is not accommodated by the WTO’s “one-size-fits-all” approach.

Not only does the WTO limit our African countries economic policy choices, in combination with the international financial institutions (World Bank and International Monetary Fund) , it prescribes a number of ideologies (read conditionalities) for sound economic management that reduces the power of governments to regulate in favour of national development objectives. The trinity of WTO, WB and IMF preach to African countries that less government is better for trade, so African states must deregulate. Specifically, meaningful and broad based health access has been severely affected by the implementation of WTO, IMF and World Bank prescriptions.[1]

So why do African states allow these type of prescriptions to be implemented? Surely they can regulate in the interest of the people? People centred policies are made “illegal”

[1] The IMF and World Bank technically prescribe nothing. They merely work with the country in question, determine policies that will be accepted by them and compile them in a report for the developing country. The developing country then submits the request for assistance in the form of a “Letter of Intent”. So technically there is no real coercion in the request, however neither the WB nor IMF will deny that they have imposed conditionalities on countries.

by the WTO, IMF and World Bank. So while governments are still held accountable by the people for the service provision, they have fewer powers with which to exercise their mandate. The decisions on the type of economic policies a State may follow are externalised to other bodies, WB, IMF and WTO. These external bodies regulate economic policy in the interest of the northern countries. African countries have slavishly followed these policies to the detriment of the welfare of their people. Even now, Africans cannot effectively exert the right to provide cheap generic drugs to their people. African governments face constraints from the imperial powers that directly undermine their capacity to govern meaningfully. The issues raised in this paper attempt to describe and address the terms of our engagement with the multilateral trading within the political context of enormous imperial (and external) control over our countries.

The WTO has come to wield authority over national governments, and has entrenched the ability of transnational corporations to exert greater influence over economic and social outcomes than many states. These bodies remain virtually unaccountable to anyone but their few selected shareholders. There are no mechanisms for "making ethical standards and human rights binding for corporations and individuals, not just governments." (UNDP 1999)

New agreements such as the WTO's Trade Related Aspects of Intellectual Property Rights (TRIPS) do provide limited space for countries to act in interests such as public health, but demand significant institutional resources and capabilities to take advantage of them. These resources are not always available to individual countries in the South. When southern countries exercise these powers they often meet major challenges. In South Africa, for example, legal processes for the compulsory licensing and parallel importation of generic drugs met not only with legal challenges but threats of sanctions from northern countries. These challenges were raised even though the measures taken were compliant with the WTO TRIPS agreement. This is a political reality that African countries must face up to, that the world trading system operates in such a way that even some rights that they do enjoy cannot be implemented.

Developing countries need to confront these trade issues if they are to meet the needs of their citizens. With the expanding scope of trade and investment agreements, no sector is unaffected. One of the options for responding to global pressures is to strengthen regional co-operation, such as for instance at the Southern African Development community (SADC) level. SADC offers a strategic platform for southern African countries to reinforce their bargaining power and co-ordinate their responses. Bargaining power is an important factor in ensuring better agreements to support distribution of benefits to Africans. Hence for example an EQUINET policy paper on WTO and public health in Southern Africa noted uneven capacities to respond to WTO measures. The paper proposed that regional co-operation be used to support country review of law and practice to protect public health in response to the WTO TRIPS agreement (Munot 2000).

Such co-operation is itself challenged by global pressures for unilateral integration, country by country, into the global economy. It is undermined by suspicions and conflicts between states within a region, and between civil society and states within countries. There is, however, an opportunity to embrace such challenges, to protect public health and to demand and ensure more equitable treatment of countries with different needs.

This demands strong state interactions to counter the increased sovereign impotence being felt by states under globalisation. It also calls for the state, civil society, professionals and elected leaderships to be increasingly informed, articulate, networked and organised in putting forward changes and policies that protect public health. Parliaments play a unique role in this. Parliamentarians in their representative role are a powerful voice on the need to strengthen respect for sustainable human development, justice and human rights. In the laws they pass and the policies they oversee and in their regional interaction, Southern African parliaments can promote policies aimed at sharing the benefits of trade and growth more widely and more inclusively.

To support this, the Regional Network for Equity in Health in Southern Africa (EQUINET) is co-operating with the Southern and East African Trade Information and Negotiations Institute (SEATINI) in a programme of work that seeks to:

(1) promote and negotiate health sensitive trade policy
(2) build a critical mass of capacity within health and trade communities to ensure that trade agreements protect public health
(3) produce materials, skills and networking towards these goals.

This paper is produced under this joint programme .

- It outlines the key global trade agreements that have an impact on health and identifies some of the options for dealing with these impacts
- It identifies the new options being proposed for trade and investment at Africa continental level and the extent to which these will confront the challenges to health of global trade arrangements
- Finally; it draws attention to the opportunities and challenges in the regional trade arrangements and their role in health.

Because of this wide scope, this paper only outlines the key features of the trade agreements. Further detail is provided in separate EQUINET and SEATINI policy discussion papers at www.equinetafrica.org and www.seatini.org.zw

2. CHALLENGES OF GLOBAL TRADE UNDER WTO

The global trade regime is increasingly defined through the World Trade Organisation (WTO), a multilateral trading regime established in January 1995 after the Uruguay Round of Negotiations (Das 1999).

WTO has established a Dispute Settlement Body and regulates a host of issues that have an impact on health including issues under the General Agreement on Tariffs and Trade, General Agreement on Trade in Services, Trade Related Intellectual Property Rights, Agreement on Phytosanitary and Sanitary Measures, Technical Barriers to Trade, Agriculture and Textiles (Das 1999). African governments have become more engaged in these issues in recent years, and are currently playing a key role in the WTO's Doha Development Agenda global trade negotiations.

In their engagement, developing country blocks like SADC face a number of general problems with this new trade regime. While the 38 sub-Saharan African members of the

WTO constitute the largest regional bloc in that body, they have been unable to meaningfully extract reciprocal concessions from the developed countries (Das 1999).

Regions like SADC are confronting development concerns that can place social, health, security and other issues above trade. WTO focuses on and makes trade concerns paramount. Countries would thus need to use to the full any protections provided within WTO agreements for other development concerns and those provided by other international standards. Examples include WTO TRIPS agreement provisions that protect government authority to carry out measures necessary in the interests of public health; or international humanitarian law provisions that make failure to provide drugs (when one has the ability to so,) a criminal violation punishable by national or international criminal courts (Fidler 1999). To use these protections countries would need to have wide familiarity with their legal options within and beyond WTO agreements.

Developing countries face disadvantages in the dispute settlement process. The WTO mechanism for dealing with disputes is to impose sanctions on trading partners who violate the WTO agreements. In practice, sanctions against wealthy countries would harm the implementing low income countries more than it would their trading partners. The WTO DSB has also ruled that unilateral action by the US is allowable, breaching one fundamental reason for joining a multilateral trade regime[2]. The DSB does not have the mandate to confer substantive interpretations on WTO agreements, but does so with impunity. Many developing countries use international law firms (often US-based) for WTO disputes because of a sense that only they are equipped to handle the complexities of the disputes[3]. These international firms charge anything from US $250 to $1,000 per hour in fees for WTO cases. Such high costs has kept many developing countries out of the Dispute Settlement Mechanism. The high cost of litigation also adds to the risk of developing countries losing cases where they are defendants by default, because their governments may not be willing to undertake the expense involved in a "full" (international law firm) legal defense.[4]

These barriers mean that there have been few challenges to developed countries denial of legitimate *market access* to the developing world. In the first five years of the WTO, out of more than 100 developing countries and economies in transition, only 20 have participated as parties and 16 as third parties in 24 dispute settlement panels. This renders the rule-based system of the WTO a nullity. It means that SADC countries should exercise extreme caution and diligence in their engagement in WTO.

SADC countries also need to be wary of how WTO measures relate to other finance and investment prescriptions. WTO is a development of and is harmonised with the wider global and international finance and investment systems. WTO measures when combined with those of the international finance and investment organisations (the World Bank and the International Monetary Fund) can limit the room for manoeuvre in national policy responses. Take for example the WTO General Agreement on Trade in Services (GATS). Under GATS, as discussed in more detail later, there is an exception that excludes services from GATS measures if they are not provided on a commercial basis or if they are not in competition with other providers. As it stands this seems

[2] Many Developing countries join multilateral organisations to protect themselves from unilateral action. Here the WTO as a multilateral fails Developing countries.
[3] Even India does this although it has many lawyers of its own for this
[4] http://www.kisanwatch.org/eng/wto/an/112701wto_an6.htm

neutral. However when one combines it with the imposition of IMF/WB conditionalities of user fees and cost recovery in services it becomes clear that the latitude for national policy making is an illusion. For example, if a public hospital uses full cost recovery it can be argued that the public hospital is not covered by the governmental exception and is thus subject to the GATS (Krajewski 2001). All GATS provisions would be applicable to this service. For example, under the National Treatment provision[5] discussed later, if the public hospital is receiving a state subsidy, that subsidy must also be given to foreign service providers to equalise the terrain of competition. Therefore it is not sufficient that only Ministries of Trade be involved in policy making, other Departments need to be involved like Finance and Health.

Deeper examination of specific WTO agreements highlights further the issues countries face and the options they have for protecting health goals.

2.1 Specific WTO agreements

There are a number of WTO agreements that have an impact on health. The Sanitary and Phytosanitary measures Agreement affects trade in food and has been used to restrict trade in food products. The standard of proof required by the WTO is high but does not provide protection in terms of the precautionary principle (e.g. for Genetically modified organisms) nor does it provide protection for minor risks (such as for potentially harmful substances). New products whose scientific evidence is confidential may be allowed even if the health risks remain uncertain.

The Agreement on Agriculture (AoA) allows for certain types of subsidies to be paid to farmers. The application of this agreement in developed countries has a trade distorting effect as developed countries sell agricultural commodities at below the real cost of production. This undermines the production in and market access of agricultural commodities from non-subsidising states and affects their earnings from agriculture (TWN 2001). SADC Health Ministers have pointed to such barriers as significant factors in undermining food security and improved nutrition in the SADC region. They compounded the already significant challenge of AIDS to rural food production (Hong 2000).

The agreement on TBT (Technical Barriers to Trade) regulates production, labelling, packaging, quality standards of pharmaceuticals, biologicals and foodstuffs. Members are directed to apply internationally agreed standards in regulating these products. There is, however, a great deal of uncertainty on the application of the agreement as the standards are themselves not set in the agreement. Low income countries are likely to be disadvantaged by weaknesses in standard setting bodies and are likely to have least capacity to manage such systems.

While nearly all WTO agreements have some direct or indirect impact on health, two agreements are discussed in more detail in this paper as they have significant current public health impact.

[5] National Treatment means that equal treatment should be given (by the government) to all investors, national and foreign.

2.1.1 TRADE RELATED INTELLECTUAL PROPERTY RIGHTS (TRIPS) AGREEMENT

Trade Related Intellectual Property Rights (TRIPs) protect a "creation of the mind; for example technological innovation." TRIPs gives these creations exclusive protection to reward the creators or innovators. The protection it offers can result in higher prices because the owners of the intellectual property right can charge whatever prices they like while they hold the protection. A patent can be registered if the product or process is new, novel and is capable of use (Das, 1999).

TRIPS excludes from its patenting protections through its Bio-diversity provision (Article 27) surgical methods, plants and animals (not micro-organisms). Plant varieties must be protected though either through patents or an independent system. SADC countries have the opportunity of creating protection for indigenous knowledge systems by creating an independent Intellectual Property Rights system, a *sui generis,* and can use the Organisation of African Unity's "Model Law for the Protection of the Rights of Local Communities, Farmers and the Regulation of Access to Biological Resources" (Ekpere 2002). This can protect local community knowledge from bio-pirates and ensure that local communities benefit materially from drugs derived from indigenous knowledge.

The TRIPS agreement *does,* however, have relevance to drug policies. It protects intellectual property rights on pharmaceutical drugs through patent arrangements that exclude third party use, offering for sale, selling or importing of such products for a minimum of 20 years from the date the patent application is filed. Civil claims around breach of patents put the burden of proof on the defendant.

Before TRIPS, many developing countries did not recognise patents for pharmaceuticals, or only for processes (and not products). This allowed countries to make copies of new drugs through identifying and patenting another pathway. TRIPS obliges all WTO member states to implement product patent protection for all drugs patented after 1995. This will make it impossible to produce generic copies for at least 20 years, and will thus raise prices. Least Developed Countries were originally required to have made their patent law TRIPS compliant by 2006. The Doha declaration has now extended the implementation date for LDCs to 2016 (TWN 2003). SADC countries that do not qualify for LDC status (e.g., Botswana, SA, Zimbabwe, Mauritius) had to be TRIPS compliant on 1st January 2000 (Munot 2000).

Currently, most essential drugs are not patented. TRIPS is thus less of an issue for the vast share of **existing** essential drugs than it is for **new and future** essential drugs, patented after 1995. The increased costs of patented drugs will put a significant burden on public health budgets. These include new drugs for HIV/AIDS, resistant Tuberculosis, Malaria and reserve antibiotics. SADC will thus face a challenge in accessing these new essential drugs at affordable prices.

The need for state regulation in drug access arises from the failure of the market to widen treatment access. For example, the market has not adequately provided for research into the drugs needed by developing countries. Medicin sans Frontiers (MSF) note that "90% of the world's health research and development is devoted to conditions that affect just 10% of the world's population. Of the 1,393 new drugs approved between 1975 and 1999, only 16 (or just over 1%) were specifically developed for tropical diseases and tuberculosis – diseases that account for 11.4% of the global disease

burden". Market forces have skewed drug development investments toward conditions like male pattern baldness, that guarantee the highest financial returns (MSF 2003). The state must thus intervene to secure the measures for drug development to reduce the major burdens of disease.

In the past, governments have managed their limited health care resources by gaining access to cheaper generic essential drugs, through importation and local licensing.[6] But this will be increasingly difficult under TRIPS, because

- tightened control over patented drugs and greater restrictions on generic production and distribution will likely see higher costs of essential and other drugs
- With 97% of drug patents held in Europe and the USA, drug costs will increasingly be paid in foreign exchange, a limited resource in most SADC countries.

Higher priced patented drugs, reduced access to generic drugs and limited supplies of foreign exchange, mean that developing countries will be hard-pressed to maintain equity in treatment access.

The concerns of the developing countries around TRIPS are twofold: one, that they will be unable to afford the patented drugs; and two, that the less expensive generic drugs will not be available. If the public sector is weakened in its ability to access and distribute generic and affordable drugs, this will further widen inequalities in health and health care. People who can afford the more expensive drugs will access these from private services, leaving public authorities to provide inadequate health care for the poor. This could potentially be exacerbated by the GATS measures that encourage private sector growth in health services, and reduce government regulatory controls over the liabilities of private purchasers and providers of health care towards wider public health needs.

There are, however aspects of the TRIPS agreement that present opportunities for protection of public health and health equity. For example, Articles 7 and 8 of the Agreement provide a strong public interest framework for the interpretation and implementation of intellectual property rights, and requires that this be done "in a manner conducive to social and economic welfare." Article 8 outlines the rights of members to adopt measures to protect public health, to prevent abuse of intellectual property rights and to prevent obstruction of international technology transfer. Article 30 of TRIPS provides for limited exceptions to the exclusive rights conferred by a patent, provided that they are limited, justified, and do not unreasonably affect the patent owner. The exceptions enable countries to parallel import the drugs or to compulsorily license them, provided their national laws provide for this.

The TRIPs agreement allows developing countries to use compulsory licensing[7] (granting a license by a state to a third party to produce a generic version of a patented

[6] Very few developing countries used the government exception provision.

a) [7] Article 31 of TRIPS enables
   i) use of a patent without the consent of the patent holder for public non-commercial use. Importation of products from a country where there is no patent protection, for instance from LDCs.
   ii) Importation of products produced under compulsory license on condition that the exporting country produces the drug predominantly for domestic use.
   iii) Granting importation rights in cases of national emergencies or extreme urgency.
   iv) For domestic production patented drugs may be manufactured:
   v) For governmental "public, non-commercial" use without informing the patent holder, provided adequate compensation is paid.

product while compensating the patent holder with a nominal royalty) or parallel imports (importing the branded product without the consent of the patent holder) in manner that supports public health.[8] The declaration from the Doha WTO meeting further clarified the authority of countries at national level to implement such measures to protect public health.

These flexibilities under TRIPs can be lawfully used without the threat of sanction. Action by southern governments and civil society protest over treatment access led to a landmark outcome at Doha in the interpretation of TRIPS to enable developing countries to secure drugs at lowest cost for public health needs. However while the Doha round made such authorities clear in the interpretation of TRIPS, there is still a struggle around this pro-health equity outcome.

Efforts have since been made by the United States to limit this authority to a restricted drug list. While the US is at pains to point out that it has imposed a moratorium on referring disputes to the DSB regarding violations of TRIPs for health reasons, it continues to use its bilateral powers to undermine perfectly legitimate rights of WTO members (Bond and Dor 2003). At the same time efforts by countries such as Thailand and South Africa's to implement the provisions of the TRIPs agreement enabling compulsory licensing and parallel importation have, "met with hostility and threats from Western pharmaceutical companies and the United States government" (Fidler 1999). Southern African countries with other developing countries proved in the Doha round that a combination the technical and public health argument offered under TRIPS and concerted political pressure from civil society and states can resist such pressures. Concerted political and civil society was brought to bear in Doha to resist the quality of the external decision making that affects Africans.

2.1.2 GENERAL AGREEMENT ON TRADE IN SERVICES (GATS)

The GATS is another WTO agreement that poses serious challenges to a government's ability to deliver services to its people. The GATS requires that government liberalise services (such as essential services like water supplies, and care services such as health care and health insurance) progressively so that higher levels of liberalisation are achieved in successive rounds of negotiations. Countries are at liberty to choose which service sectors they would like to liberalise, however the balance of power in trade negotiations usually favours the developed countries who have more to gain from liberalisation. The GATS imposes general obligations that are applicable to states and covers all sectors. On the other hand, there are specific commitments (like market access and national treatment) where that governments can choose to make commitments in specified sectors, and limit some of these.

Should countries not effectively manage the GATS process and if full commitments are made under the GATS, this would in effect commercialise the provision of essential services like health care. This will open the way for wider privatisation of health care, further segmenting services and drawing resources from the public and non profit health services of health care. This leaves those who cannot afford private services to an underfunded

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vi) By a private entity under compulsory license if it is required to meet the public health needs of a country.

vii) Under compulsory licence in a case of emergency or extreme urgency (TWN 2003).

[8] Paragraph 4 of the Doha Declaration

public system. The growth in the private sector increases the direct and indirect costs to the public sector by offering better pay to professionals and reducing the number of fee paying clients at public sector institutions. The effects of complete liberalisation of the Health sector could thus be to enhance inequity in the resource flows between public and private health systems.

The GATS regulates trade in services. Health services are an identified service sector under the GATS. Health services are also included under the GATS heading of 'professional services', which covers medical and dental services as well as the category of 'services provided by midwives, nurses, physiotherapists and paramedical personnel'. GATS also covers insurance services, including health insurance, and 78 countries have already committed those services to liberalisation under GATS. This has caused particular concern in those countries which base their health systems on social insurance programmes, since few health ministries were informed that their trade negotiators had committed their health insurance sectors to GATS (EQUINET et al 2003).
GATS also regulates the provision of other basic services that are interdependent with health, such as water and electricity. The GATS uses a bottom up approach which means that countries are free to limit the liberalisation of service sectors in a schedule, the services listed being referred to as specific commitments. Countries may also provide horizontal limitations to service provision across all sectors. Hence for example, South Africa has provided that its nationals must own a particular percentage of entities established in South Africa.

There are also general obligations in GATS that apply to signatories without national discretion. These include provisions for most favoured nation treatment[9], regional integration[10], domestic regulation, transparency[11] and disciplines on monopolies and exclusive service providers[12].

The GATS provides for 4 modes of delivery on services, namely:

a) Cross border trade, where trade takes place from one members territory to another state's territory and only the service crosses the border. Eg: Telemedicine from one country to another.
b) Consumption abroad, where a consumer moves to another country to use a service. Eg; Plastic surgery safaris are an example.
c) Commercial presence, where a foreign service supplier sets up operations in the territory of another member. Eg; where a South African corporation sets up a private hospital in Zimbabwe.
d) Movement of natural persons, where a person enters another country to provide a service. Eg; Zambian doctors going to work in Botswana.

As countries have weak or no data collection on the real levels of these four modes of trade in services, it is difficult to predict the full impact of the GATS in the SADC region (Raghavan 2002). It is important for countries to improve their information base on the trade in health related services. Looking at the GATS provisions more closely it provides some indication of their likely impact.

[9] Article II.
[10] Article V. This is particularly problematic provision as it allows non-RTA state's entities easy access to RTA markets. See in particular the implication of Article V.6.
[11] Article III.
[12] Article VIII.

GATS also "locks in" liberalisation. Countries who have liberalised certain sectors face almost insurmountable barriers in changing commitments. Liberalisation, especially of essential services, under the GATS should be done with care as they are virtually permanent. The needs of citizens may change and require different service delivery mechanisms and States must ensure that they have the right to regulate and intervene in markets especially where basic services are concerned. This policy flexibility that retain our sovereign powers to ensure that basic needs of citizens are met.

Services, unlike goods, have trade barriers that are not just tariff related. Services liberalisation is about the effect of regulations. The GATS thus imposes disciplines on the type and nature of regulations that a state may pass to pursue its policy goals. In some instances these GATS disciplines may unduly limit the policy options that a state may pursue, for instance the pursuit of affirmative action in South Africa (Steytler 1999).

GATS provides that regulations within a state must be based on "objective and transparent criteria" and should not be "more burdensome than necessary." Any regulation should not be "unnecessary barriers to trade in services." The meaning and import of these terms is unclear and value laden. A country that has entered into commitments under GATS thus faces great uncertainty.

For example regulations on the marketing of baby foods, such as those passed in Zimbabwe, are just one example of the type of 'restrictions' which could be under threat. These prohibit the promotion of breastmilk substitutes for babies under a particular age. Yet such regulations could be interpreted as 'unnecessary' if the WTO decided that there were other ways of achieving the same public health objectives – even if there were specialist evidence to the contrary. Hence when countries schedule commitments, they need to also ensure the appropriate safeguards that protect the state's right to regulate in the public interest. As countries have national discretion in making commitments, they are urged to exercise caution in making commitments if they are not sure of their impact. Some countries in SADC have however already opted to make liberal commitments in their health services, now invoking GATS limits their ability to regulate these sectors.[13]

These limits and requirements can have negative impacts on health systems. There is concern that GATS might foster the privatization of health care and health insurance in some countries, which might erode universal access to health services and worsen health prospects for the poor and disadvantaged (Fidler 1999). When decisions about basic services are included under the GATS, state powers to intervene are limited. State powers to regulate and direct services provision should not be externalised but should be retained, protected and enhanced because the State is more able than the WTO to respond meaningfully to the needs of its people.

The governmental exception under the GATS is very narrow.[14] The exception does not cover services provided on a commercial basis nor services provided in competition with other providers. In many health service sectors, there are private and public providers. In this case the public provider of the service will be covered by the GATS. Where public institutions charge fees for their services, these activities puts them under the GATS.

[13] South Africa and Zambia are cases in point as they have entered "none" or no restrictions on the foreign entry of services and regulation under GATS.
[14] Article I.3 and generally Krajewski 2001.

The national treatment clause[15] under the GATS requires states to treat foreign service providers in a formally equal or formally different manner in order to equalise the terrain of competition between domestic and foreign service suppliers. The GATS does not define what a 'level terrain of competition' is and so leaves unclear the latitude states will have regulate foreign providers. This includes the extent to which foreign service suppliers will be exempted from certain necessary domestic regulations set specifically to regulate foreign practice in the interests of clinical quality or health equity.

Market access[16] is specific obligation that members can enter into under GATS. Market access prohibits certain types of actions by states, like limiting the number of service suppliers or the value of transactions in a service sector based on economic needs tests. States have in the past controlled market access and used economic needs tests as a way of ensuring that health services are equitably distributed, that health insurance does not skim low income or high risk groups or to proactively direct health investments towards national health goals. Unless states positively provide for the type of market access they are allowing, the more negatively framed market access provisions in GATS could limit their ability to ensure national health goals, including health equity. For example, states promote cross subsidisation so that services which cost less subsidise services which cost more. In many countries, profitable services, such as international telephone calls, have subsidised the development of less profitable but more socially beneficial telephone services in rural areas. Risk pooling and cross subsidies between rich and poor, healthy and sick are important to ensuring universality in health care cover and equity in access to health care. However removing cross-subsidisation is an essential step in services privatisation. States would need to ensure that market access limits under GATS do not limit their right to ensure cross subsidisation. This would allow corporations to divide up integrated health care services, extract the more profitable ones and leave behind a higher risk pool to the public sector.[17]

Some aspects of the GATS regulates foreign investments. Investments refer money coming in from international sources to provide a service. Not all investments are good or productive. Therefore governments in all parts of the world have used investment policies to promote their economic and development objectives. However what the GATS does, in effect, is to create a set of rights of investors but without creating a set of corresponding obligations. Foreign investments require profit repatriation increasing the demand on already scarce foreign exchange. Government regulation of investments is also required to ensure that some benefit does in fact accrue to the host state.

GATS impacts on migration of health personnel both in the pull factor that will come from the opening of private providers and from measures that facilitate the flow of personnel to work in other countries, including provisions for recognition of qualifications. GATS may impose limits on domestic regulation to retain staff and exacerbate a "brain drain" in health services professionals from the developing to the developed world, further eroding health system capabilities in developing countries (Fidler 1999).

Even the seemingly neutral transparency requirement can become very cumbersome for developing countries because it requires publication of policies and regulations and responses to queries about services, such as from international companies seeking to

[15] Article XVII
[16] Article XVI
[17] Unlisted or new monopolies and exclusive service providers are prohibited under the GATS.

enquire about trade opportunities. This requires substantial resources can impose an inordinate burden on health administrations, diverting resources from other priority tasks.

The previous paragraphs offer suggestions on what SADC countries can do to enhance their response to GATS (improve their information base on current trade in services, ensure trade negotiators are informed about the health impacts of liberalized trade in services that have an impact on public health, protect governmental authority to regulate or provide for cross subsidization in areas essential to public health and so on). However at this stage, in recognition of the potential risks and in the face of inadequate information on real dangers, a number of organizations[18] presented a submission in the 2003 World health Assembly that *all* WTO member countries should:

1. Make no GATS commitments in the health sector or other health-related sectors;
2. Conduct a comprehensive 'health check' on any other GATS commitments proposed by WTO trade negotiators, with the active involvement of health ministries and civil society;
3. Call a halt to the current WTO negotiations on rules governing domestic regulation;
4. Call for a change to GATS rules which restrict countries from retracting commitments already made under GATS (Equinet et al 2003).

2.2 General Options for SADC responses to WTO agreements

While specific latitudes exist within WTO agreements their use depends on the capacity and organisation within SADC countries to take these up.

For example, in the Agreement on the Application of Sanitary and Phytosanitary Measures raised earlier, to exploit the latitude within the agreement, SADC states would need to have national SPS Committees. Some SADC states have these while others do not. In some countries the SPS committees are not fully functional (Mtei, 2003). Capacity to engage with the SPS agreement is lacking and developing countries are effectively excluded from the standards generation process. SADC level initiatives may enhance the capacity for members to take advantage of the provisions of this agreement, however imperfect they are. In addition greater capacity to engage with SPS issues will allow African trade officials to challenge unjustified blocking of exports from international markets. At regional level there are, however, no mechanisms established yet to monitor progress on harmonization and integration of SPS Measures (Mtei, 2003).

SADC countries also need to strengthen themselves as a negotiating block. For example, trade negotiations currently require developing countries to drop their tariffs on imports of agricultural goods, which is really the only defence mechanism from subsidised cheap imports. SADC countries must resist tariff reduction on agricultural commodities, demand greater market access to rich northern markets and demand an elimination of subsidies. Agriculture is the predominant economic activity in Africa.

[18] Equinet, International People's Health Council, Medact, People's Health Movement, Save the Children UK, Wemos, World Development Movement.

Successful agriculture will not only help us meet nutritional needs but have multiplier effects on all areas of human life.

Regional level agreements can be used, such as in the TBT agreement, that protect member states' health interests through setting regional standards on pharmaceutical quality.

While SADC states have these options there is a wider problem to contend with. There are a number of "new issues" that are being tabled for discussion at the WTO. These are competition, investment, trade facilitation and transparency in government procurement. These issues have been forced onto the table at the Doha Ministerial meeting, against the consent of most developing countries. At this stage the Draft Ministerial text envisages that concrete decisions will be taken at Cancun when in actual fact, African countries and other developing countries in general, still feel that their concerns are being marginalized on these particular issues. In the face of uncertain impacts of WTO regulations developing countries would not want to enter into commitments until they have had the opportunity to fully understand their implications. New issues may have serious and unintended consequences which should be first analysed and assessed.

Of particular concern are the pressures to establish an agreement on investment at WTO. Efforts to put investment in a 'free trade' context negates the fact that states need to control investments. Since most investment is of a financial non-productive nature, control over the type and nature of investments is required is states are to ensure economic goals are achieved (Nabudere 1989). An agreement on investment at the WTO carries the risk of limiting the authority of member states to regulate in the interest of national goals. Without adequate controls over speculative flows of capital, the flow of investments can be positively harmful (Khor 2002, SEATINI 2003). In addition, all investments within our countries need to leave benefits for our people and government regulation of investments is required.

3. AFRICAN CONTINENTAL RESPONSES TO TRADE

Harmful impacts of trade and investment regimes have already been identified in the disease burdens in Africa. The continent has particularly suffered the impact of structural adjustment programs on health and health services. As pointed out in an EQUINET discussion paper, the effects of such macro-economic and investment policies have included disincentives to health-seeking behavior, lower health care utilization rates and declines in the perceived cost and quality of services. Household expenditures on health care and ability to meet major health care expenses dwindled, as did nutritional status (Bond and Dor 2003). Health services price inflation and additional costs put significant burdens on household disposable incomes and on food consumption. The consequences in urban drift and migrancy contributed to the spread of the HIV/AIDS pandemic. Effects on health workers have also mainly been negative, including cuts in the size of the civil service, wage and salary decay, declining morale, and the brain drain of doctors and researchers. The effects on health system integrity included declining fiscal support; difficulties in gaining access to equipment, drugs and transport (often due to foreign exchange shortages accompanying excessive debt repayment); and the diminished ability of health systems to deal with AIDS-related illnesses. Adjustment, liberalisation and privatisation policies have led to increased commodification of basic health-related goods

and services (such as food, water and energy) that have made many of these services unaffordable.

The lack of development within Africa and its retrogression as far as trade goes prompted a number of responses from African leaders. African leaders decided to continue with plans for pan-African unity by establishing the African Union. The African Union is a continental political structure that has adopted the New Partnership for Africa's Development (NEPAD) as a plan of action. The AU specifically identifies the promotion of good health as a fundamental objective.[19]

The New Partnership for Africa's Development was signed in October 2001. It is an agreement that aims to promote accelerated growth, reduce poverty and stop Africa's marginalisation in the global economy. It is regarded as "a comprehensive integrated development plan that addresses key social, economic and political priorities in a coherent and balanced manner" with the explicit intention "to accelerate the integration of the African continent into the global economy."[20] "NEPAD is driven by two premises:1) that African economies and states must adjust their economies in order to provide the enabling conditions for their further penetration by global capital and 2) that they must recast their political systems to conform more clearly to the liberal quasi-democratic structures of the West (Bond, 2001)

NEPAD aims to attract foreign direct investment and to disburse to African governments that meet its criteria of good governance. NEPAD has established health priorities under its Sectoral priorities. It aims to:

- have health systems that meets needs and supports disease control effectively;
- ensure support to have a sustainable healthcare delivery system
- reduce the burden of disease amongst the poorest people;
- encourage co-operation between traditional healers and medical doctors.[21]

The action plan to achieve this includes:

- Strengthening participation in processes to acquire affordable drugs;
- Mobilising resources to build effective disease interventions and secure health systems
- Collaborate with international agencies and donors
- Encourage governments to make health a greater budgetary priority
- Jointly mobilise resources for capacity building.

In addition it identifies actions to reverse Africa's brain drain.

While NEPAD has been commended for the initiative taken from within the continent, there are also criticisms of the manner of its introduction and its content (Ndlovu 2003)

One weakness identified was in its top-down introduction in that the people it affects were not consulted (Sanders and Meeus 2002, Tandon 2002, Bond, 2001). For parliaments, civic groups and others far greater consultation and debate is called for to ensure input to and ownership of the plan. This weakness has been acknowledged.

[19] Article 3 of the Constitutive Act of AU 11 July 2000.
[20] www.nepad.org
[21] www.nepad.org.

In relation to content, NEPAD at its core is intended to be a magnet for the attraction of FDI, taking this as the basis for remedying Africa's underdevelopment (Tandon 2002, Bond 2001). It argues for greater integration into the world economy (and combined with FDIs) which it says, will result in greater economic development and growth resulting in the reduction of poverty. This approach is criticised as limiting the diagnosis of the problem (Tandon 2002). It is partially correct, but misses other factors and thus makes faulty policy prescriptions, namely more global integration and more FDI's. This negates the problem of too much of the wrong kind of integration into the global economy, which means that FDIs cannot on their own solve Africa's problems.[22] In addition the debt burden on Africa is so great that by accepting the debt Africa is placed in the unenviable position of subjecting even NEPAD to the largesse and "goodness" of international agencies, investors and donors.

Current systems of global integration have already proved harmful to health systems in Africa, as highlighted earlier. Under such policies Inequality has risen within and between countries. The income gap between the fifth of the world's people living in the richest countries and the fifth in the poorest was 74 to 1 in 1997, up from 30 to 1 in 1960 and the widest this gap has ever been. The sensational flow of boom and bust we have come to associate with global financial markets understate the huge groundswell of chronic poverty that follows market turmoils, the collapse of job markets and of real wages and the fall in budget allocations to social sectors (Loewenson 1999). Market led reforms in Southern Africa have been directly or indirectly associated with reductions in real per capita allocations for health and to weaker redistribution of health resources towards the poor. The current experience of macroeconomic reform in many African countries has led to a rising share of public funds being allocated to debt servicing, reducing the real allocations to health and leading to an increased demand on communities to finance health. Public spending on health in the region is at or less than 3% of GDP, and has declined under structural adjustment programmes in a number of countries (Loewenson 1999).

Global integration under current conditions reinforces wealth flows south to north. The response from the G8, a group of the Heads of State and Governments of eight major industrialized countries, to NEPAD signals how the programme will be interpreted to sustain the current disadvantageous path to African integration:

- Instead of supporting Africa's efforts to redress its production problems they said, that they will support "efforts by African countries to work towards lowering trade barriers on imports from the rest of the world." The effect of this will be to increase imports which would undermine regional integration and further de-industrialise Africa (Tandon 2002).
- The G8 intends to use WTO processes that as already indicated African countries have difficulty with
- G8 approaches to supporting African efforts to build sustainable health systems in order to deliver effective disease interventions are based on promoting pharmaceutical industry access in these countries. The G8 has remained silent on the right of developing countries to make full use of TRIPs safeguards discussed earlier in order to protect the public health of their citizens (MSF 2003). In contrast G8 countries have encouraged developing countries to contribute to the goal of affordable medicines by reducing their (developing countries) tariffs and fees on discounted and donated products (G8 2003).

[22] Tandon identifies that capital is not always productive and that FDIs in the long term can lead to greater economic instability. More generally see Tandon, Y. " Fallacies about the theory of FDIs: its ideological and methodological pitfalls." SEATINI Working Paper Series No. 3.

- The G8 has not committed itself IN practice to opening market access to African food products, while themselves pushing for lower trade barriers to their food products. They state that they will "[apply] our Doha commitment to comprehensive negotiations on agriculture aimed at substantial improvements in market access, reductions of all forms of export subsidies with a view to their being phased out, and substantial reductions in trade-distorting domestic support.[23] These very same promises were made at the Uruguay Round of Negotiations which have not materialised (Raghavan 2002). There is no express commitment to abandon subsidies! Meanwhile African countries have been forced to liberalise agriculture and have to compete unfairly with subsidised G8 products.
- The G8 paths to essential services do not reinforce universal public provisioning models used in Africa. They state that they will "[Support] reforms in the water sector aimed at decentralization, cost-recovery and enhanced user participation."[24] The implementation of cost recovery has had disastrous consequences in South Africa and other parts of the world. By pursuing cost recovery programmes access to safe water will be limited for the poorest and increase Africa's disease burden.
- The industrialised countries have retained their discretion to deal with African governments only on their own terms (irrespective of what NEPAD dictates) when it says, " In support of the NEPAD objectives, we each undertake to establish enhanced partnerships with African countries whose performance reflects the NEPAD commitments. Our partners will be selected on the basis of measured results." It is not clear who will measure the results or what those results should be. This leaves the G8 room to rescind its commitments or to select partners that it chooses unilaterally.

This 'global business as usual' response, and the lack of real confrontation in NEPAD of the serious distortions in the global economy, raises concern over its ability to address the significant health equity concerns of the continent, such as making investments in primary health care and wider interventions to deal with poverty, undernutrition, unemployment and poor environments, AIDS, resolving inequities in access to quality health care, ensuring treatment access through equity pricing, providing adequate resources for health interventions and securing public health protections over commercial interests in international trade negotiations (MSF 2003; Equinet 2003). African reliance on G8 goodwill and largesse is misplaced, given the degree of self-interest that governs trade relations. While it is becoming increasingly clear that such deep economic, trade and social inequities are not in the interests even of the wealthy, the commitment to addressing them is still extremely weak[25].

[23] Khor 2002 states a caution, "the qualifying term 'trade distorting' can be used by the major developed countries to suggest that the so called 'green-box' domestic support measures… are not covered by the negotiations on reduction." page 16.

[24] www.nepad.org

[25] MSF state that, "If individual governments and international institutions cannot keep their promises, and if international trade rules can so clearly be structured to protect the interests of the few over the interests of the many, the viability of the current system will be put into question (MSF 2003)..

4. SADC REGIONAL OPTIONS FOR HEALTH PROMOTING TRADE

Given this scenario, how far can the development of regional co-operation through SADC confront such negative global trends and strengthen African responses?

The development of SADC arises as an outcome of historical interactions in the region in trade, culture, politically, socially and economically. The Southern African Development Community (SADC) flowed directly from the South African Development Coordination Conference (SADCC). The SADCC was created in 1980 and was intended to provide a platform of unity against apartheid South Africa. It was not intended to create a regional trade agreement. SADCC was transformed into SADC in 1992 and broadened its concerns to facilitate regional economic integration and development. South Africa started to participate in SADC in 1994. SADC now has 14 members (Chauvin and Gaulier 2002).[26]

The Summit of Heads of States of Heads of States (which has a chairperson and Vice Chairperson) is one of the organs of SADC that has the power to make binding decisions. The Tribunal, which can also make binding decisions, is set up to provide interpretations of the treaty. The SADC Council, another SADC organ, has limited powers to bind member states domestic policies directly. Once the Council has made a decision, it is up to the SADC members themselves to incorporate Council decisions into their domestic jurisdictions. While the lack of formal processes can indicate a lack of political will to cede political sovereignty (in the sense of establishing a supra-national SADC body) the successful negotiation of a SADC Free Trade Agreement was a major achievement by any standards (Ng'ong'ola 2000). The FTA is monument to the capacity and willingness of SADC members to commit to challenging processes in the interests of the region.

As a large market, SADC offers opportunities to promote the development of economies of scale in production and services. Many of the health and health interdependent issues (like communicable disease control, drug procurement, health personnel migration, drug procurement, quality standards, respones to AIDS, disease surveillance, water and energy provision) can be addressed from a regional perspective and can tap regional capacities. SADC has now restructured to cover the following sectors:

- Food, agriculture and natural resources;
- Transport, communications, energy, water, tourism, et al;
- Human resources, labour, health, et al;
- Social and human development.

A SADC Parliamentary Forum has been established, although not considered a formal organ of SADC. The Parliamentary forum, "is a consultative body" and like the Council, cannot effect legislative changes in members domestic jurisdictions (Ng'ong'ola 2000) However as a political body within SADC, it enhances the democratic scrutiny over

[26] The Republic of Angola, The Republic of Botswana, The Democratic Republic of Congo, The Kingdom of Lesotho, The Republic of Malawi, The Republic of Mauritius, The Republic of Mozambique, The Republic of Namibia, The Republic of Seychelles, The Republic of South Africa, The Kingdom of Swaziland, The United Republic of Tanzania, The Republic of Zambia and The Republic of Zimbabwe.

issues and activities within the region. In addition it creates another avenue in which different members can build consensus and discuss a number of common interest issues. As a body it has the power to influence policy and stimulate the development of capacity.

In 1996, a SADC Trade Protocol was signed[27] with the goal of establishing a Free Trade Area by 2008. Work has been done on tariff reduction schedules, rules on the origin of goods and services, the elimination of non-tariff barriers, harmonization of customs and trade documentation and dispute settlement mechanisms. 11 of the 14 SADC members signed the SADC Trade Protocol which took effect on first of September 2000. The SADC Protocol on Trade establishing the FTA provides for a process of tariff reduction with the intention of establishing a free trade area amongst members by 2008 (SURF 2000). Fully liberalised trade is only anticipated to take place in 2012 (Chauvin and Gaulier 2002).

There has been a limited focus on agricultural goods and services under the SADC work programmes but progress is being made (Mtei 2002). A Health Protocol has also been developed. The SADC Health Sector was established to support the efforts of members to attain an adequate standard of health for all people of the region. The Health Protocol has been in the process of ratification by member States since August 1999. The process of ratification was significantly slowed down because of the restructuring process within SADC. At present the sector is short of two member States for the Protocol to enter into force (SADC 2003). SADC has as one of its fundamental guiding principles in Health the commitment to, "ensuring equitable and broad participation for mutual benefit in regional co-operation in health."[28]

4.1 Challenges for health promoting trade

As noted by EQUINET in 2000, significant health gains were made in SADC countries in the 1970s and 1980s, particularly through primary health care and public health interventions, such as improving water and sanitation, food security and nutrition. There have been set-backs in more recent years. Many SADC countries now have relatively high levels of deprivation, with poor access to essential services as well as low levels of human development (such as income and educational status) relative to their economic development levels. Significant disparities have emerged across geographic areas, "ethnic" or "race" groups, and between men and women (EQUINET Steering committee 2000).

Parallel inequalities have emerged in the health sector, in access to TB control and treatment, antenatal care coverage, access to safe water and access to quality primary care facilities and referral services. High rates of preventable diseases, child mortality and malnutrition are differentially distributed between geographic, ethnic, gender and income groups. From the range of data available, it is becoming clear that poorer segments of the population have been most negatively affected in terms of reduced access to health.

[27] Article 22 of the Treaty establishing SADC provides that Member States may conclude Protocols as may be necessary in each area of cooperation. (Schlemmer)
[28] Article 2.

Inequalities are widening in relation to the inputs to health, such as literacy, educational status (particularly for women), income, household savings and assets, housing tenure and standards, access to safe water, sanitation and reliable energy supplies. Those for whom community integration is worst, including single mothers and elderly people living alone, often suffer the most severe health inequities. These inequalities have intensified vulnerabilty and risk in the HIV/AIDS epidemic. Research shows that HIV moved quickly from the more socially and economically powerful, to the poorer and economically insecure. The impact of AIDS on the poorest groups has been to precipitate deeper poverty, and facilitate the intergenerational transmission of poverty within households.

The 2000 United Nations Regional Human Development[29] report on SADC indicates that while between 1985 and 1990, the value of the HDI increased in most of the member countries, between 1990 and 1994, it decreased in most of the countries in the low human development category and in four of the countries in the medium human development group. Between 1990 and 1997, life expectancy at birth fell in all except four of the fourteen member countries. HIV/AIDS has been a primary factor in the reductions in life expectancy and in-rates of economic growth (SURF 2000). Malaria has also been a major cause of under-five mortality[30].

Macroeconomic policies have also intensified inequalities in household food intake, income and employment levels and access to education, safe water and other non health sector inputs to health. There are great inequalities within SADC members and ten out of fourteen countries have Gini coefficients in excess of 0.50. These inequalities exist in ownership, distribution of land and access to resources in general (SURF 2000). SADC member countries have hugely differing GDP per capita, from USD 156 in Malawi to more than USD 7000 in Seychelles. Even among the richer countries in the group (Mauritius, South Africa, Namibia and Botswana), the per capita income numbers are deceptive as marked inequality prevails within countries.

Structural adjustment and market reforms have affected the level and composition of public expenditure, reducing provision of and access to primary health care services, particularly in low income groups. Reduced access to health care and other safety nets have exacerbated the 'poverty ratchet' of ill-health. Structural adjustment programmes, global trade agreement impacts and other liberalisation reforms have weakened the state's role as a direct health provider, increased the intensity and breadth of interests within the health sector and made the systems through which these interests are expressed and adjudicated more important in ensuring health equity.

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[29] "Human development is the process of enlarging people's choices so that they can live a long and healthy life, be educated, have access to resources for a decent standard of living, enjoy political, economic, social and cultural freedoms, and have human rights, self-esteem and opportunities for being creative and productive… The HDI is a composite of three components, namely, longevity (measured by life expectancy at birth), education (measured by the combined gross enrolment ratio at primary, secondary and tertiary levels, and adult literacy rate) and standard of living (measured by real per capita income)." UNDP 2003

[30] In an Africa wide study Malaria was responsible for 20% under five mortality, constituted 10% of the continent's overall disease burden, accounted for 40% of public health expenditures, 30-50% of inpatient admissions and up to 50% of outpatient visits in areas with high malaria transmission (MSF 2003).

These trends towards inequity in health have been significantly affected by how the state has targeted its resource allocations for health. Recession and structural adjustment have reduced public spending on health. The lowest income countries have been under greatest pressure to introduce cost recovery systems that undermine the fairness of their financing patterns.

Staffing constraints, poor conditions of service, inadequate resources for health professionals and related factors have seen plateauing or declines in coverage and quality of health care, especially at primary level. While liberalisation has enabled a wider spread of private providers, the benefits of this have been limited to a small share of higher income groups, and it has intensified attrition of skilled personnel from public to private for profit health sectors. Even though many health professionals are trained in the region sub-Saharan Africa has the lowest share of medical professionals for its population (Sanders and Meeus 2002). EQUINET / HST have highlighted mounting problems in the active recruitment of health professionals from poor to rich countries, intensifying these inequalities in health (Padrath et al 2003).

Physician/1,000 people ratio (World Bank, 2001)	
High-income countries	2.8/1,000
Middle-income countries	1.8/1,000
Low income countries	0.5/1,000
Sub-Saharan Africa	0.1/1,000.

(Sanders and Meeus 2002)

There have however been periods where health systems in the region have made significant improvements in health status in high risk groups and reduced health inequalities, by

- redistributing budgets towards prevention;
- improving access to and quality of rural, informal urban and primary care infrastructures and services;
- deploying and orienting health personnel towards major health care problems;
- supporting personnel with adequate resource inputs;
- ensuring fairer distribution of resources between the public and private sector providers;
- investing in community based health care;
- encouraging effective use of services, by improving dissemination of information on prevention and early management of illness; and
- removing cost barriers to primary care services at point of use.

These experiences indicate the need for an economic and trade regime that enables the state to organise and sustain equitable health systems, particularly in allocating public resources towards those with greatest health needs, and towards forms of health care most appropriate and accessible to these communities, particularly primary health care strategies. It also indicates that health promoting trade should enable a more equitable outcome of the private-public mix in health services and facilitate a better distribution of health personnel.

As noted in the discussion on WTO, achieving this becomes more possible when SADC countries use regional frameworks to:

- strengthen their negotiating power and capacity in global frameworks to use the latitudes provided
- confront unfair global trade regimes such as the DSB in WTO and the AoA for their exclusion of southern interests
- build non economic and trade regimes within the region that drive internally driven growth
- strengthen the basis for global integration terms more favourable to their populations and producers.

How far have the economic and trade policies within SADC facilitated proven positive policies and practices within the region?

4.2 Trade and investment in SADC

SADC is one of the richest regions in Africa. The SADC land mass covers cover 9066840 square km (the equivalent of the USA or China), has a population of over 194 million and a combined GDP of US$178 billion in 1999 (Chauvin and Gaulier 2002). Its size and resource base provide both economic and social potential for addressing the health challenges.

One constraint to realising this potential lies in sluggish overall growth. Between 1960 and 1980, there was little difference in average annual growth of sub-Saharan Africa compared to other developing regions like Mercosur and South East Asia. The gap in growth rates has however increased during the 1980's, when average annual growth in sub-Saharan Africa was just 1.9% (Chauvin and Gaulier 2002). Sub-Saharan Africa's economic growth slowed in 2002 to 2.5 percent, down from 2.9 percent in 2001 (USTR 2003).The growth rate was below the 2.8 percent registered by developing countries in 2002, but well above the 1.7 percent experienced by the world generally. 2002 was the second consecutive year that sub-Saharan Africa surpassed average global growth rates but lagged behind the pace of developing countries as a group (USTR 2003) Relative to other developing regions, SADC and sub-Saharan African countries have generally had more sluggish growth, despite major efforts made.

Weak investment has also undermined growth. Intra-SADC investment takes the form of foreign direct investment (FDI), portfolio investment and loans. While the amount of investment is increasing in the region, it remains relatively insignificant. The main flow of intra-SADC investment is from South Africa. With weak regional integration, the limited market size of the economies of most individual SADC member countries makes them unattractive to investors (SURF 2000).

Trade in primary commodities under falling terms of trade and global barriers to market access have also undermined the household and national resource base for addressing health problems. SADC economies have a high and historic dependence on exporting primary commodities and are characterised by a lack of industrialisation (SURF 2000). Given the hostile global trade environment, barriers to market access for these commodities and worsening terms of trade for agricultural commodities, even improved production output is associated with reduced economic growth. Generally Africa, generates nearly 30% more exports today than in 1980, yet suffers from declining

commodity prices and worsening terms of trade (TWN 2003) and their value has crashed by more than 40% because of falling terms of trade (Bond, 2001).

Several SADC states also suffer from macroeconomic instability, which undermines both human development and regional integration. High budget deficits, high rates of inflation, high levels of external public debt and
exchange rate instability have discouraged both trade and investment. However even those that have reduced budget deficits and achieved a certain measure of macroeconomic stability have not necessarily experienced a higher rate of economic growth (SURF 2000).

This is not due to weak global integration, but to the unfair terms of this integration. SADC countries are more open to the global economy, contrary to popular belief, on trade than is the EU. For example exports are 58 percent of GDP for Botswana and 52 percent of GDP for the rest of SADC. In contrast, the EU exports 14 percent of its GDP (Lewis et al 2002). Despite this high degree of 'global integration' sub-Saharan Africa accounted for only 1.4 percent of world trade in 2001, virtually unchanged from 2000 (USTR 2003). This statistic is important when considering Africa's relative powerlessness in multi-lateral trade negotiations.

How far has this been overcome by improved intra-regional trade? Trade within the region has been increasing. While in 1980, 1.6% of total SADC imports were supplied by SADC members, by 1996, this share amounted to around 10.2% (Chauvin and Gaulier 2002). During the 1990s, intra-SADC trade grew faster than the total SADC trade. Intra-SADC trade grew from 27.8 per cent of the Gross Domestic Product of the sub-region in 1991 to 39.5 per cent in 1996[31]. There are two causes for these increases, the upward trend in intra-SADC trade from the late 1980s and, second, the entry into SADC of the five new SADC members, namely: Namibia, South Africa, Mauritius, Seychelles and the Democratic Republic of Congo (SURF 2000).

However even this trade has not equitably generated the resources for economic and employment growth to resource health improvements at household and national level. Firstly, trade expansion has been concentrated in a few countries in the region. South Africa dominates regional trade, supplying 77% of intra SADC exports in 1999. Zimbabwe is the next most important exporter to the region with 15% of exports (Chauvin and Gaulier 2002). South Africa's trade surplus with most SADC countries has been rising since the early 1990s, facilitated by its economic dominance and by trade liberalisation policies in other countries (DPRU 2000). While South Africa is a large exporter to SADC, it is a minor importer from SADC countries (Ng'ong'ola). This unbalanced trade is a source of concern, particularly in areas where it results from trade diversion owing to tariff advantages for South Africa on the SADC market or from the increasing difficulty (for SADC countries) of penetrating a protected market (Chauvin and Gaulier 2002).

Unilateral national integration into global markets through national liberalisation programmes has thus neither provided the economic returns to protect health and health systems, nor the integrated regional markets to attract investment.
While intra-regional trade has increased and a commitment to a free trade area established, the benefits of this still seem to be limited to few countries in the region.

[31] Including informal cross-border trade, the actual intra-SADC trade ratios may be even higher.

There are also a multiplicity of trade arrangements in the region that divert or even contradict some of these nascent SADC regional arrangements. The South Africa-EU FTA is expected to affect other regional trade activities. The US Africa Growth and Opportunities Act and the EU's Economic Partnership Arrangements provide concessions that stimulate trade with US and EU on terms that look more favourable than those offered from intra-regional trade. These concessions are, however, purely discretionary and may be withdrawn at any time (USTR 2003).

The Southern African Customs Union (SACU) exists within SADC as regional free trade agreement that has had the effect of converging the economies involved toward a closer integration through trade since 1990.[32] (Jenkins 2000) The RTA of SACU has thus been more effective than the SADC RTA, and a trade imbalance exists between SACU and SADC, with greater export opportunities for SACU countries (Chauvin and Gaulier 2002). SADC in some respects is in direct competition with SACU. For example, SACU is currently negotiating a free trade agreement with the US that has direct implications for SADC, particularly as SACU is the primary importer of products from SADC countries.

These other trade agreements are not harmonised with SADC and can generate tensions in the formation of a free trade area in SADC, particularly where they are seen as unilateral or undermining the RTA process (Leis et al 2002). The dominant economies of the region have both benefited more from current trade arrangements, leaving economic development unbalanced and persistent internal inequities. In this context, countries have been reluctant to cede decision making to SADC supra-national structures. This further compromises the deepening of regional economic and trade integration. Unbalanced trade and internal tensions also weakens SADC regional unity in global trade negotiations, particularly if large economies like South Africa are seen to be adopting trade and investment agreements that will tie policies in other SADC members without ensuring that meaningful benefits accrue to them.

The Windhoek Treaty that was used in restructuring SADC identifies barriers to deeper regional integration less as formal trade barriers and more as arising from capacity shortfalls. Enhanced regional economic integration is thus seen to demand better economic systems, infrastructure, technical and human capacity and better links between the production systems of countries. The problems in the SADC region arise from "underdeveloped production structures and inadequate infrastructure, rather than tariff or regulatory barriers"(USTR 2003).

This section confirms that addressing such capacity shortfalls across the region are important to more equitably distribute the benefits of regional integration and drive the process in a sustainable manner. The Windhoek Treaty hints at the need for a more equitable development path *within* the region to drive a more proactive thrust to regional integration. If regional integration is a basis for strengthened extraction of opportunities from the global economy, then it demands its own internal processes that ensure that the benefits of this integration are not inequitably distributed.

More equitable distribution of the economic benefits of regional integration is also important for health as it increases the likelihood that the health and social gains from

[32] SACU was originally formed in 1910 with South Africa and the BLS (Botswana, Lesotho and Swaziland) and renegotiated in 1969. Namibia, part of South Africa until independence in 1990,only formally joined SACU as an independent state in 1990.

improved trade will be more widely distributed across countries and communities in the region. It is also important if the level of political and economic integration and trust is to be achieved to establish the positions and bargaining power needed to confront global trade and investment issues from a position of strength.

5. CONCLUSIONS

SADC countries have to face a wide variety of challenges to improve the health of her people. Despite these challenges, SADC countries have a range of options that they can pursue to promote health, health care, health equity and efficient use of resources.

The paper demonstrates the significant challenges that global trade and investment policies can and will have on health. It warns that to tap any opportunities from these agreements, countries need to be in a stronger position to protect national policy interests that are fundamental to equitable and sustainable development.

This paper supports the thrust towards strengthened regional integration as a means to confronting these global trade and investment challenges, while also calling for more equity within the regional integration process. This is suggested to be necessary to share capacities, information and resources in the region and to build the market size, resource base, production systems and regional trade necessary for the more internally driven development, growth and trade path that will meet longer term development and health goals.

The table below summarises opportunities for African's link through regional bodies to promote development. By ensuring that a wide variety of policy tools and options are available to our governments (as opposed to permanently giving up the right to these policy instruments), they can increase the impact of their interventions. Parliaments can also ensure that the legislative frameworks provide for these policy tools, and provide voice and oversight to support such processes.

Challenge	**Opportunity and Action**
Make TNC's more accountable	Create standards for private conduct by regulating essential health and health related services.
Ensure policy flexibility for sovereign states to regulate in the interests of promoting and safeguarding public health.	Review international agreements that encroach and limit governments ability to promote and safeguard public health. From the review, firstly seek to backtrack on the commitments that limit government flexibility in key areas. **Action:** Consider policy options that have been made illegal through the trading system and their potential impact on increasing sustainable service delivery by consulting members international trade departments.

Challenge	Opportunity and Action
	Prevent/reduce any further international trade commitments that will limit policy flexibility, specifically: • New or further GATS commitments; • Agreements on the "New Issues" – Competition, Transparency in Government Procurement, Trade Facilitation and Investment. **Action:** Consult and make input on governmental negotiating positions as regards public health and interdependent disciplines.
	Use the maximum amount of flexibility granted in international agreements to promote and safeguard public health interests. **Action:** Legislate and use the maximum allowable exceptions under the TRIPs agreement. Promote the right to sovereign domestic regulation. Consult and make input governmental negotiating positions
	Play a role in bilateral agreements between countries and international financial institutions (WB/IMF) agreements that seek to limit policy flexibility or extend obligations. **Action:** Consult Departments of Finance on conditionalities attached to loans.
Develop agriculture for food sovereignty	Seek greater market access and better prices for produce. **Action:** Liaise with Departments of Agriculture and International trade and make inputs that promote food sovereignty. Seek the elimination of agricultural subsidies and resist the demand for a reduction in agricultural tariffs. Promote sustainable agriculture to support the nutritional needs of citizens.
Promote the development of regional standards	The SPS and TBT agreements both provide space for SADC to develop regional standards and disciplines. These will help to reduce the barriers to internal trade and regional dependency. **Action:** Establish and support local SPS and standards generating bodies.
TRIPs	Protect indigenous knowledge systems by implementing independent protection for plant varieties. **Action:** Legislate independent intellectual property rights regimes to protect local innovation.

Challenge	Opportunity and Action
	Promote public health by using the TRIPs flexibilities by passing legislation that allows: • compulsory licensing, • domestic production, • parallel importation of drugs to ensure adequate access to drugs.
	Regulate the research and development of essential drugs for addressing regional disease burdens. **Action:** Regulate and direct research priorities.
	Seek a declaration from the WTO Ministerial conferences that prevents the patenting of life forms. Consult and make input on governmental negotiating positions
GATS	
Regulation of trade in essential services like health, water, electricity and education.	Ensure that member states ability to regulate and provide essential public services is not limited by not making further commitments and reversing or restricting current commitments.
Disciplines on transparency	The administrative burden to ensure health services are transparent to domestic and foreign stakeholders may be time consuming and costly. **Action:** Transparency should be reasonably provided within country capacities to prevent resource diversion.
Promoting equity	Economic needs tests, monopolies and exclusive service providers are an effective way of promoting pro-equity goals and policy flexibility should be retained.
NEPAD	
	Interrogate and engage with NEPAD health action plan to identify areas of co-operation and potential collaboration.
	Advocate and promote regional interests and priorities.
	Promote complementary regional trade efforts through other regional structures.
	Enhance member states bargaining strengths in all fora by co-operating in negotiations on common interest issues.

New Issues	
	Refuse to make commitments on competition, government procurement, trade facilitation and investment.
Promotion of equity guided policies	Prioritise: • SADC stipulated 12,5% minimum budget distribution to health • Capacity building for a central role by member states to sustain health systems, particularly through public providers • Health-trade networking and joint reporting on impacts of trade agreements • Promotion of vertical equity in resource allocation • Effective state organisation and regulation to ensure an equitable public-private mix • Legal provisions to secure national authority in areas of public good and public health • Application of public health principles in adjudicating trade impacts

Given the capacity constraints at the national, regional and international level, greater co-ordination and harmonisation of positions will increase the bargaining power of SADC countries and reduce the strength of the divisive techniques used by developed countries.

Representative voice is needed to call for visionary long-term policies, that withstand changes in individual leadership. Oversight is needed of economic and trade policies and of utilisation of natural resources so that there is better use and more equitable distribution of resources in the region. Oversight of the interaction between the various agreements being made by individual members or blocks within the region needs to ensure that different bodies do not undermine the overall development plan for the region.

The bottom line is that the deep economic, social and political inequities that underlie inequities in health are driven by a global trade and investment system that operates in the self interest of wealthy countries. While it is becoming increasingly clear that such economic, trade and social inequities are not in the long term interests even of the wealthy, the commitment to addressing them is still extremely weak, particularly within trade systems. If we are to have a sustainable impact on health equity, we cannot rely on benevolence. It is rather the strength, direction and unity of our own actions that will secure our rights to development.

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APPENDIX 1

REGIONAL TRADE AGREEMENTS

Regional trading agreements commonly refer to trading arrangements between member countries in which certain preferences are granted to members to the exclusion of other countries (du Plessis et al 1994) There are a number of types of regional trade arrangements like free trade areas, customs unions, common markets and economic unions. Free trade areas remove all tariffs and other state barriers to regional trade between members. In a free trade area, members maintain their own individual tariffs against non-member countries. In a customs union, members remove trade barriers between themselves but maintain a common external tariff against non-members. The Southern African Customs Union is an example. A common market is a customs union with the free movement of the factors of production (capital and labour) between members. An economic union is a common market which aims to have full economic integration with supra-national authorities for joint economic policy decision making like the European Union (du Plessis et al 1994). Regional integration is allowed under the WTOs GATT and GATS under articles XXIV and V. Essentially regional integration is an exception to the most favoured nation treatment rules common in international trade arrangements. Most favoured nation treatment requires that a favour granted to any one country must be extended to all other countries. The regional integration exceptions in the WTO agreements allow members of an RTA to discriminate against WTO members in favour of RTA members.

There are many economic reasons for economies integrating into regional trade areas, namely:

i) increasing economies of scale and consumer surplus;
ii) increasing the size of the market and creating multiplier effects;
iii) fostering regional rather than international dependencies;
iv) utilising comparative advantages and developing specialisations; and
v) promoting regional development. (du Plessis et al 1994) (Knox 1994).

Developing countries may also use the larger numbers created within an RTA to shore up their bargaining power. The theory of regional integration does not imply that the gains from RTA will be equitably distributed, “the gains from trade, based on specialisation, may be offset by the welfare losses of unemployment and deterioration in the terms of trade (SURF 2000) This means that regional integration itself is not a solution to development challenges, it is one of the means that can be adopted.

When production of goods and services is moved from high cost producers to low cost producers, this is referred to as trade creation. However, under a regional trading arrangement, the opposite may also occur, that is moving from a low cost producer to a high cost producer, which is referred to as trade diversion (du Plessis et al 1994 and Knox 1994).

The success of RTAs depends on a number of factors. When RTA economies are complementary rather than competitive (i.e. they produce different sets of goods and services instead of producing similar goods and services) there are better prospects for integration (Knox 1994). However, du Plessis et al are of the view that competitive economies (in a customs union) is a better predictor of success.

There are around 11 economic blocs (RTAs) in Africa (Chauvin and Gaulier 2002). There are about 9 in sub-Saharan Africa, which has one of the highest numbers of RTAs in the developing world.[33] This multiplicity adds to the complexity of regional trade and is often used by major trading partners as a means of dividing African countries to their detriment. As mentioned above the concepts of trade diversion are trade creationare important to regional integration processes. Studies have found that trade creation dominates trade diversion for the region under all FTA arrangements in various models that have been analysed (Lewis, Thierfelder and Robinson 2002).. There is an assumption that trade creation is always better than trade diversion. However, it may be necessary to encourage trade diversion in order to allow regional industries and service suppliers room to grow and develop into viable and competitive enterprises.

Due to globalisation, greater integration of the world economies, the fear of marginalization of Africa and Africa's relative powerlessness against major trading partners there is renewed interest in regional integration. Progress in Africa regional integration has nevertheless been slow because of "overlapping membership, the lack of authority and bureaucratic sophistication to deal with bigger powers [and] political turmoil in some countries (Chauvin and Gaulier 2002). So despite numerous attempts at creating regional power blocs, there are a number of challenges facing regional integration.

[33] The nine regional organizations, with problematic overlapping memberships, are: (1) the Economic Community of West African States (ECOWAS), with 15 members; (2) the West African Economic and Monetary Union (WAEMU) with eight members, all also belonging to ECOWAS; (3) the Common Market for Eastern and Southern Africa (COMESA), with 20 members; (4) the Southern African Development Community (SADC), with 14 members; (5) the Southern African Customs Union (SACU), with five members, all also belonging to SADC and two to COMESA; (6) the East African Community (EAC), with three members, two belonging to COMESA and one to SADC; (7) the Inter-Governmental Authority on Development (IGAD), with seven members in eastern Africa; (8) the Indian Ocean Commission (IOC), with five members, four belonging to COMESA and one to SADC; and (9) the Central African Economic and Monetary Community (CEMAC), with six members.