Regional Network for Equity in Health in Southern Africa

EQUINET POLICY Series NO. 12

The WTO Global Agreement on Trade in Services (GATS) and 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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This paper has been developed with the financial support of the International Development Research Centre (Canada) and the Rockefeller Foundation

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List of abbreviations and acronyms

AB	Appellate Body
CESR	Covenant on Economic, Social and Cultural Rights
CSOs	Civil Society Organisations
DSB	Dispute Settlement Body
DSU	Dispute Settlement Understanding
GATS	General Agreement on Trade in Services
GATT	General Agreement on Tariffs and Trade
GMO	Genetically Modified Organism
IFIs	International Financial Institutions
IMF	International Monetary Fund
IPRs	Intellectual Property Rights
LDCs	Least Developed Countries
MFN	Most Favoured Nation
MTN	Multilateral Trade Negotiations
NAFTA	North American Free Trade Agreement
NEPAD	New Partnership for Africa's Development
RTA	Regional Trade Agreements
RTAs	Regional Trade Agreements
SAPs	Structural Adjustment Programmes
SEATINI	Southern and Eastern African Trade, Information and Negotiations Institute
TNCs	Transnational Corporations
TRIPS	Trade Related Intellectual Property Rights
UNCTAD	United Nations Conference on Trade and Development
USCSI	United States Coalition of Services Industries
WB	World Bank
WTO	World Trade Organisation

EXECUTIVE SUMMARY

Equity in health refers to fairness and the basis on which the poor and the marginalized in society can appeal to the good conscience of all citizens to get treatment that is not unfair. Due to limited resources in any given society, competing claims for equity have to be balanced through the allocation of public resources by the state and the imposing of regulations on the society. In southern Africa as well as other countries of the world, the health sector is affected by policies formulated in other sectors (Equinet Policy Series No.7). This sector is further affected and constrained by some multilateral trade agreements. In this paper we look two such agreements of the World Trade Organisation (WTO): the General Agreement on Trade in Services (GATS) and, to a lesser extent, the Trade Related Intellectual Property Rights (TRIPS). The study goes into greater detail in trying to depict how, through GATS, national policy options that support equity in health are threatened.

GATS lacks clarity on many issues. This makes it difficult for developing countries to stand up for their basic rights when faced with powerful trading partners such as the EU. A typical example is found in the first article of GATS, which specifically excludes from scope, 'services supplied in the exercise of governmental authority'. However, the same article goes on to define such a service as one 'which is supplied neither on a commercial basis, nor in competition with one or more service suppliers'. In most countries, public provision of services like health and education coexist with private sector provision. This means, therefore, that in such cases, public services are covered by the agreement. For example, water is a service that was traditionally under the provision of government authority, but is now being provided by private corporations too. For southern African countries, services such as water, which is a major factor that contributes to health needs, is still under government authority and it is the government's responsibility to make such services adequately available to all its people. However, since these services now fall under GATS, they should be treated as commercial commodities, if full GATS commitments are entered into. The government cannot prevent other business players from providing these services. If it cannot compete, it has to leave the provision of these services to the competent corporations. People who can afford to will pay for the services; those who cannot, will have to do without. So, while GATS purports to improve the efficiency of services delivery, it marginalises the majority poor within poor countries.

While TRIPS agreement enforces the protection of intellectual property on one hand, this agreement in its existing state does not promote access of essential drugs to developing countries, and hence impacts on the provision of health services. The agreement in its current state advocates protection of pharmaceutical corporations interests. The Doha declaration clarified the rights of Members to use compulsory licensing for parallel importation or domestic manufacture of patented drugs. By including this provision in the TRIPS agreement it was envisaged that it would help alleviate the scarcity of access to technology that TRIPS would create. However, the most powerful nation of the world, the United States found the Doha declaration too broad, with reference to public health problems. The US is proposing that the access to essential drugs be limited to 'HIV/AIDS, malaria, tuberculosis or other infectious epidemics of comparable gravity and scale, including those that may arise the in the future'. The Doha-mandated deadline passed on 31 December 2002 for WTO members to come up with a solution to public health crises exacerbated by unaffordable patented drugs. With only some few months left before the 5th WTO Ministerial Conference in Cancun, Mexico, nothing is expected to materialise before the conference, and the poor of Africa will continue to suffer.

With these realities and challenges of globalisation, the role of governments in fighting for the rights of their people should not be undermined. This paper recommends some policy options for consideration by southern African governments to ensure that GATS does not compromise the provision of public health for their people. These include:

- Public debate on GATS to expose the hidden threats of the agreement especially in the provision of public healthcare.
- Carrying out impact assessment of GATS before entering into the next phase of the negotiations, or at least in parallel with on-going negotiations.
- Ensuring that transparency issues under GATS are dealt with at the multilateral level as opposed to bilateral level.
- Insisting on the removal of public health from GATS.
- Retaining the right to create monopolies and exclusive service providers prospectively if new needs or technologies arise or if cross subsidisation is necessary for the viability of the enterprise.
- Safeguarding regulatory powers of national policy-makers from domestic regulation threats by including expansive definitions when committing a sector or including the decision-making institutions into the process.
- Challenging the 'lock in nature' of GATS liberalisation by including sector-specific time limitations for domestic review of commitments under GATS.
- Strengthening institutional and regulatory frameworks including appropriate competition laws.
- Safeguarding policy space in order to meet national policy objectives.

These recommendations are not exhaustive and are not easy to implement given the complexity of GATS. Trade negotiators, regulators, civil society organisations and all stakeholders need to improve their cooperation to ensure that GATS does not undermine pro-equity goals.

PART I of the paper provides a brief introduction of the link between trade and development as related to health in general. The history of the World Trade Organisation (WTO) is also briefly introduced as it relates to the General Agreement of Trade in Services (GATS). Then a brief outline of the contents of GATS is given focusing on those areas relevant to public health generally, to health services and to their financing.

PART II presents opportunities and threats posed by GATS for public health and health equity goals and policies in southern Africa, in terms of both general obligations and specific commitments across all modes of supply. This is the main focus of the paper. The paper then explores the specific areas of concern and their implications for healthcare systems in southern Africa, particularly in terms of key health equity issues, viz: public health and preventive healthcare, health infrastructures, health financing, health personnel distribution and the regulatory framework for the health sector. The paper further explores the impacts given the current level of trade in these areas and reviews the costs and benefits of possible impacts of GATS on these areas of health system. The paper also looks at the effect of GATS in these areas relative to other WTO agreements, e.g. TRIPS.

PART III identifies the policy space and options for southern African countries to protect public health and pro-poor health systems. The paper identifies key areas for follow-up work in the southern African region in terms of information and knowledge gaps to be met, policy and legal issues and institutional capacities nationally and regionally to strengthen the protection of public health in relation to GATS. This includes the assessment of the options southern African countries have for taking up protection of public health within and beyond the procedures and dispute settlement mechanisms set within GATS.

THE WTO GLOBAL AGREEMENT ON TRADE IN SERVICES (GATS) AND HEALTH EQUITY IN SOUTHERN AFRICA

INTRODUCTION

Globalisation 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 and those areas of human development in the public domain (outside markets), such as education and health, have suffered this rather ruthless drive towards satisfying the profit motives of the biggest players in the market. This demands, therefore, that the state, civil society, professionals and elected leaderships are increasingly informed, articulate, networked and organised in putting forward changes and policies needed to protect public health.

SADC and all other developing countries need room within the existing multilateral trade framework, to provide reasonable access to healthcare for all citizens. The WTO's TRIPS and the General Agreement on Trade in Services (GATS) do pose serious challenges to governments' ability to deliver adequate health services to their people. Such agreements should be challenged so that their implementation does not undermine the access to drugs and access to the public health services.

It is in this light that the Regional Network for Equity in Health in Southern Africa (Equinet) is cooperating with the Southern and Eastern African Trade, Information and Negotiations Institute (SEATINI) in a programme of work that seeks to:

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

This has led to a programme of work that aims to:

- investigate, analyse, disseminate and support dialogue and awareness on the major implications of WTO agreements on public health and health equity in southern TRIPS and GATS;
- propose policy responses from southern Africa and SADC and support the development of capabilities for and engagement on those policy options;
- network southern Africa, SADC and northern professionals, civic and state personnel towards strengthening public health and generating pro-equity oriented responses to WTO agreements;
- strengthen southern African parliamentary committees on health to exercise their legislative and oversight roles in relation to public health and health equity implications of WTO agreements;
- monitor changes, developments, negotiations and developments in other countries and regional power blocs that affect the interests of southern Africa as a region; and
- publish and disseminate findings of the work for wider distribution in Africa.

PART 1: TRADE DEVELOPMENT AND HEALTH

Link between international trade and development

The global social – and in particular health – crisis that afflicts the South today can be traced to the European colonisation of South America, Africa and Asia. To feed the global market economy new crops, mainly for export, were introduced in the colonies; new laws and social structures were imposed; new technologies and consumption patterns, which were totally alien, took hold. Subsistence food production gave way to commercial crops and raw materials to feed Europe's industrialisation. Agrarian societies in the colonies were profoundly transformed. Fertile lands were given to grow cash crops leaving less land to grow food to feed the local population. Food scarcity became a permanent feature and this affected the nutritional health status of local people (Third World Network, December 2001; Hong, August 2000).

Imperial policies and the market economy did not end with colonialism; it was given a new name with 'development'. With independence and the post-war 'development decades' that followed, Third World states became tied to the world system of trade, finance and investment with transnational corporations (TNCs) in the forefront of the economic order. To enable the newly independent states to catch up with their former colonial masters, it was believed that economic development was the answer.

The law of the market was to enhance this specific kind of economic development. Under this new economic regime, governments privatised state enterprises such that industries, banks, hospitals and utilities (such as, water, sewage and sanitation) were sold off to the private sector in the name of efficiency. Public expenditure for social services was cut. Government control and regulation was reduced. The role of government was to ease conditions for companies to invest and increase their profits. The free market was allowed to rule, meaning there should be no impediments to the free flow of money, goods, investment and services.

Trade liberalisation, which has become an extremely fashionable policy prescription, should not be seen as a panacea, as it is only one of several potential instruments for development. To realise its potential, and enable liberalisation to work in favour of development requires conditions tailored for the specific requirements of each country. The 'optimum' conditions of trade differ from country to country, depending on such factors as the stage of development, resource endowment, and conditions relating to market access and prices of traded products. The multilateral trading system should, therefore, be sensitive to the differential needs of different countries. However, the WTO's approach has been a 'one size fits all' approach. Albeit there are special and differential treatment provisions in various agreements, they do not cater adequately for the needs of developing countries.

The United Nations Conference on Trade and Development (UNCTAD) found that the rapid and extensive trade liberalisation undertaken by the poorest countries during the 1990s failed to benefit the poor. In fact, it was associated with rising poverty, with the countries worst affected being those that liberalised most.[1] Furthermore, African governments themselves have become increasingly sceptical about the benefits of trade liberalisation. In a paper submitted to the WTO on the current negotiations on Market Access to Non-Agricultural products, Ghana, Kenya, Nigeria, Tanzania, Uganda, Zambia and Zimbabwe pointed out that in the past two decades most African countries have undertaken wide-ranging reform measures in the context of the structural adjustment programmes under the IMF and the World Bank. They indicated that the main emphasis of these reforms has been on trade liberalisation. According to these countries, these

[1] UNCTAD, 2002.

reforms have lowered trade barriers but the broad-based development that was expected to ensue has remained elusive. Indeed, empirical studies show that industrial growth has fallen behind GDP growth in sub-Saharan Africa since the 1980s with de-industrialisation in a number of African countries being associated with trade liberalisation (WTO, May 2003).

Trade should not be an end in itself but a means to balanced, equitable and sustainable development. Aspects of trade that can serve this goal should be encouraged and promoted. Aspects that are inappropriate, at least during particular periods or in particular conditions facing a country, should be treated with caution.

Trade and equity in health

Where trade supports development then there is a positive outcome. However, trade can also challenge development by undermining it and raising concerns about basic human rights, especially where basic services are concerned. The International Covenant on Economic, Social and Cultural Rights (CESR)[2] captures the right to health in article 12, 'The State Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.' Similarly the controversial New Partnership for Africa's Development (NEPAD)[3] attaches some priority to the issue of health and uses the WHO definition of health 'as a state of complete physical and mental well being.' As a basic human right, the right to health is recognised in the national constitutions of many southern African states.

When scarce resources in a country are being allocated to various needs and demands there are many considerations that need to be taken into account. A parliament deciding on how it will spend its tax revenues frequently has to make these decisions based on legal obligations in the constitution, the mandate given to them by the voters, the needs of society, and other factors, so that they can direct the money in ways that best meet the needs of society at large. One of the core human rights principles that have developed is the concept of equity. Equity is related to fairness and justice and is the basis on which the poor and the marginalised in society can appeal to the good conscience of all citizens to get treatment that is not unfair. On the other hand equality can be understood as the same treatment for all. However, because resources are limited in any given society competing claims for equity have to be balanced through the allocation of public resources by the state and the imposition of regulations on society.

The concept of equity needs to be balanced with the need for efficiency. This means that the cost of providing a service will influence the amount of assistance a person will receive. This is a process that medical practitioners frequently engage in where there are limited resources.

Distributive justice refers to a decision allocating resources when the outcome of the decision is fair. On the other hand, *procedural justice* means that any decision allocating resources is fair if a fair procedure was followed (Mooney, 1994). Distributive justice could mean that an unemployed patient gets free assistance from a hospital in contrast to an insured patient who has to pay. This means that more resources are directed to users who are less able to pay. Where all people are required to apply for health assistance from a hospital and a committee makes the decisions between two or more applicants based on guidelines, then that can be called *procedural fairness.* With this procedural justice it would not matter that the unemployed person was rejected and the employed person was granted assistance. Application of the principle of equality is not always distributively just even though the same (or equal) procedure was used. Therefore equal treatment does not necessarily result in equity, since it is possible that those most in need do not receive the help despite the formally equal treatment.

[2] UN General Assembly Resolution 2200 A (XXI) 16 December 1966.
[3] Signed October 2001, Abuja Nigeria available from www.dfa.gov.za.

Dealing with these issues at a practical level is not as simple though. If two patients have the same degree of the same disease then resources can be allocated equally between them. However, how does one make a decision about allocating resources where one patient is at a far more advanced stage of the same disease? Horizontal equity can be referred to as 'equal access for equal need'. Horizontal equity can also inform our analysis of non-fee paying patients in public hospitals with private patients in the same hospital.

Dealing with two patients with different diseases and differing needs, and allocating resources between them is called vertical equity. For instance, how does one decide whether to purchase insulin for a diabetes sufferer when the resources could be directed at buying morphine for a terminally ill cancer patient? Vertical equity can be viewed as 'unequal access for unequal need'. In a broader sense, EQUINET (2000) argues that given the extreme levels of deprivation in SADC countries, claims for vertical equity policies become more urgent so that services to those most in need can be provided. Vertical equity, therefore, is linked to distributive justice and procedural justice.

Making vertical and horizontal equity decisions is indeed a complex process, and a number of writers have complained about the lack of attention this aspect of equity has received in research as it will guide the primary decision makers on how to allocate scarce resources (Mooney, 1994).

For our purposes, in the context of the GATS debate, we use a loose definition of distributive justice: assisting those most marginalised in society to gain better access to quality healthcare (Mooney, 1994) and minimising the deprivation of those who are most in need by reducing their inequity. EQUINET (2000) on Townsend states that: '[material or social] deprivation may be defined as a state of observable and demonstrable disadvantage to the local community or with wider society or nation to which an individual, family or group belongs.'

The challenge to fulfil these equity ambitions requires that the:

- state is able to provide a level of resources to ensure basic services for all; and
- overall management of health allocates resources in a distributive just manner that maximizes the net benefits to society.

The essential problem with GATS and equity in healthcare is that GATS favours a market based approach that supports trade in health. All considerations of equity are secondary and trade issues take primacy (Labonte, 2002). GATS places the social need for health within a business context, which is not appropriate nor beneficial to society as healthcare is a basic human right that should not only be determined by profit considerations. Labonte (2002) points out that government action to protect public health and the environment has been undermined by the WTO under the Sanitary and Phytosanitary Measures agreement, simply because these measures were trade restrictive. Koivusalo (2002) states that GATS even challenges regulations that prohibit the advertising of hazardous products (Koivusalo, 2002).

Basic health market indicators in Southern Africa

The WTO takes a market perspective on all issues including health. According to WHO (2002), child mortality and morbidity rates in Africa are amongst the worst in the world, with millions of people dying yearly from preventable diseases. SADC countries have high levels of malnutrition, maternal mortality and stunted growth in children under five years, relative to developed countries and other developing countries (EQUINET 7, 2000). The World Bank reports that the average per capita health spend in sub-Saharan Africa is US$3 while the WHO says US$60 is required to deliver a basic level of healthcare (Bond et al, 2003). SADC countries therefore face severe challenges as even the implementation of user fees will only contribute a mere 5% of recurrent expenditure (Gilson, 1997)[4] and may be subject to external influences resulting in

[4] Gilson, L. 'The lessons of user fee experience in Africa' 1997 Health Policy and Planning 12 No 4 p 273 to 285

variations in revenue. User fees have been implemented without necessarily ensuring equitable access, since most exemption policies for the poor are ineffective (Gilson, 1997). Inherently the funding for social services in Africa is underfunded and unstable.

Since GATS and other globalising forces move health services to the marketplace, it is important to get a sense of the size of the domestic market for health services. The size of the health markets in sub-Saharan Africa is tiny compared to the rich northern countries. The total per capita spend on health in individual southern African countries (in US$ terms) with the exception of South Africa, is 10% the level it is in the United Kingdom and about 3% of the health spend in the US (WHO, 2002). When adjusting health expenditure per capita (in purchasing power parity US dollars), no SADC country exceeds 10% of the amount spent in the high-income countries (EQUINET 7, 2002). The markets in southern Africa are minuscule when compared to the international markets. Southern African countries have a characteristically high expenditure on private health, with South Africa, Malawi and Zimbabwe having more than 50% of the total expenditure being private. Only South Africa and Namibia have well developed insurance or pre-paid schemes (WHO, 2002). However, high levels of spending – particularly in South Africa – cover a minority of the population (Cleary, 2000).

In terms of access to physicians, even well resourced South Africa has 0.6 physicians per 1000 people compared with a high country average of 2.8 (EQUINET 7, 2000). The rest of the SADC countries enjoy between 0 and 0.3 physicians per 1000 people, indicating a severe shortage especially when compared to high income countries. These statistics do not reflect the rural–urban bias that exists in many countries where rural areas are typically under serviced.

Most other southern African countries have approximately a fifth of their health expenditures dependent on external agencies, with Malawi receiving 86.7% of resources coming from outside. Mozambique also has a high degree of external dependency. Health budgets in southern Africa are constrained by policies of fiscal discipline, devastating external debt repayment obligations and huge time and energy spent on trying to fit domestic priorities into donor priorities. Most SADC countries are dependent on external trade and aid as sources of income.

The above gives an indication of the level of demand, or need of the population. The statistics show a level of deprivation in the allocation of resources to citizens within a country. Given these demands, the necessity of allocating resources efficiently and utilising them effectively is increased.

Health outcomes are a result of both non-health and health sector inputs (EQUINET 2000). Provision of safe drinking water is, for example, one of the major inputs in the health sector. Provision of water is increasingly under the privatisation threat worldwide. This is being done through the emerging private-public partnerships often linked to TNCs. The Fortune magazine of May 2000 predicted that: 'Water promises to be to the 21st century what oil was to the 20th: the precious commodity that determines the wealth of nations.' Here is an example of how the corporate world is going to make huge profits from GATS. At the second World Water Forum held in the Netherlands in 2000 it was ascertained that, in a quarter of a century, there would be a world water crisis. In order to counter that crisis the following solutions were prescribed: make efficient use of water by using genetically modified organisms (GMOs) that use less water; do not leave water under the control of indigenous people because they waste water – it should instead, be channelled to corporate hands (note that there are health-related fears associated with GMOs.) The inability of governments to provide universal access to water leads to the market solution of privatising water. This kind of conclusion is one of the bases for the greatest push in the privatisation of water that is being experienced all over the world.

GATS requests recently tabled by most developed countries, especially the European Union, make 'water for human use and waste water management' a brand new GATS sub-sector (WDM, April 2003). Botswana and South Africa are two of the countries in the SADC region whose water

supply is targeted by the EU GATS requests. The Botswana Waste Utilities Corporation maintains a policy of cross subsidy in order to protect domestic consumers at the lowest band to have access to water supplies (WDM, April 2003).[5] Although South Africa has already made commitments in some of the sub-sectors, it has not yet opened up water supply. Should these countries respond positively to the EU's request, water will certainly become too dear to the already suffering people of Soweto (Muroyi, May 2002). If safe water becomes a scarce commodity to the poor, outbreaks of diseases like diarrhoea, cholera and malaria will not spare the poor.

World Trade Organisation Agreements

Since the level of health enjoyed by a population is dependent on a number of factors, there is a need to analyse the context within which health and the provision of other essential services are handled. In an increasingly globalised world, international institutions, like the WTO, provide the framework for the conduct of international trade in goods and services and for the protection of intellectual property rights (IPRs). The WTO originated at the completion of the Uruguay Round of Multilateral Trade Negotiations (MTNs) in 1994. The agreements of the Uruguay Round came into force on 1 January 1995. In this process, the General Agreement on Tariffs and Trade (GATT), got changed into the WTO, with a much wider coverage, including those areas having no direct link with the trade in goods.[6] The WTO's general premise is that global free trade must not be impeded by national governments. National governments must apply the 'least trade restrictive measures' to achieve environmental and health protection, for example. More alarming is the fact that the WTO requires that laws of all member states comply with WTO rules. Although it is an intergovernmental organisation, it is the TNCs that sit on important advisory committees of the WTO or powerful member countries, which decide policy and set the agenda. This means that, under the WTO, the rules of the governments are weakened in favour of the TNCs. The dominance of corporate power in the WTO can be better understood through the operation of GATS as highlighted in the following chapters. The WTO, therefore, serves as the government of the world order for corporate interests.

The WTO contains a framework for the enforcement of rights and obligations to Agreements. The main elements of the WTO agreements in respect of goods consist of disciplines regarding tariff and non-tariff measures. To ensure continuance of competitive opportunities, the WTO agreements provide for protection against unfair trade practices. The WTO agreements also cover the area of trade in services and also the standards of protection of intellectual property rights.

All these agreements have been integrated within a common framework of enforcement through the dispute settlement process, which is meant to ensure protection of rights and the discharge of obligations of members. A member may take recourse to this process when it is dissatisfied with another member for some action it has taken or for its failure to take some action. The dispute settlement system is a very powerful instrument to pressure governments to fall into line (Hong, 2000).

Under the Dispute Settlement Understanding (DSU), administered by the Dispute Settlement Body (DSB), the latter will establish a panel comprising normally three persons. These persons are bureaucrats from member nations with expertise in trade policy and trade laws. Upon receiving written submissions from the parties in dispute, the panel members will submit a report to the DSB. When a party makes an appeal, it will be referred to the Appellate Body (AB) of seven members. The report of the AB has to be adopted by the DSB. The panel will hear only the trade representatives of the national government. Citizens groups, the press or other non-commercial interests are not allowed in.

[5] Unless Botswana lists the monopoly and specifically retains the right to cross subsidize, it will be rendered illegal on liberalization of the sector under GATS.

[6] GATT was not an organisation; it was only an agreement administered by the Interim Commission for the International Trade Organisation (ICITO). The WTO has a formal status of an intergovernmental organisation that had not been available in the GATT.

Once a ruling is made, the country, which has lost its case, can change its national laws to conform to WTO rules, pay permanent compensation, or face punitive trade sanctions from the other member country. The DSB has had a record of ruling against health, environmental and social concerns. These decisions invariably favour corporate interests. For example, in 1997 the WTO dispute settlement panel sided with the United States in its challenge to a European Union ban on beef treated with growth hormones, which have been scientifically linked to cancer and other serious diseases. In a January 1998 appeal the WTO upheld its decision ruling that the EU law violated WTO rules. In July 1999, the US imposed WTO approved retaliatory sanctions on the EU for its refusal to accept US hormone-treated beef. The WTO Appellate Body had ruled that the EU ban was not based on adequate scientific evidence. The EU's defence was that the ban was justified by the Precautionary Principle (Hong, August 2000).[7] In this particular case, the WTO's rejection of the Precautionary Principle puts public health under threat and undermines the ability of states to protect the health of its citizens.

The DSB derives its mandate from the DSU, which is part of the Uruguay stable of agreements. Article 3.2 of the DSU states clearly that the DSB cannot make substantive interpretations of the text and can neither add to nor diminish the rights of the parties to the agreement. However, it is clear from the beef hormones case above that the DSB does indeed engage in substantive interpretations of the WTO agreements. The DSB can only interpret the text of the agreements that are in dispute but cannot give a particular meaning to the text that is not directly covered by the agreement. The decision could have been made in favour of the Europeans, on the same text, since it is equally plausible. If there are two equally valid interpretations of the same text then how is it possible for the DSB to make a decision that is not a substantive interpretation?

This role that the DSB has assigned to itself is outside of its mandate and it contravenes the rights of the parties. Developing countries are at more risk from the actions of the DSB, not just because they exceed their mandate but because the enforcement of the rulings of the DSB allows the winner of the case to impose sanctions on the offending member. Developing countries who impose sanctions against their developed country counterparts are in most instances likely to suffer more from the imposition of sanctions than the developed country. In effect, this means that the DSB is a powerful enforcement mechanism to discipline developing countries, while it allows the developed countries virtually a free license to undermine the multilateral trading system. This inequity in power makes a mockery of the 'rules-based' system of the DSU.

The larger developed countries engage in trading 'WTO sins' so that they do not frequently bring complaints against each other but rather settle their differences by calculating the costs of each other’s non-compliance and evening them out between themselves.

In effect, this means there is a dual legal system within the WTO: a system for the powerful that favours the developed world and a punitive system for the developing world. Besides resource constraints to wage expensive legal suites, developing countries are very unlikely to benefit from decisions at the WTO and even if they do they will be able to do very little to enforce their claims for compensation or treatment according to the agreements they have signed.

[7] The Precautionary Principle allows countries to protect their citizens based on scientific evidence of risk, but before the scientific proof of harm is conclusive.

PART 2: THE GENERAL AGREEMENT ON TRADE IN SERVICES AND ITS IMPLICATIONS FOR HEALTH EQUITY

Overview of GATS

The WTO represents a system for regulating all aspects of trade in services from negotiating concessions through to settling disputes between members. However, regulation of services at a multilateral level is relatively new. Trade in services was brought under the rules of the multilateral trading system at the conclusion of the Uruguay Round. This is covered by the World Trade Organisation's General Agreement on Trade in Services (GATS) which came into force on 1 January 1995. GATS lays down the basic rules to conduct international trade in services; it aims to promote international trade in services and to remove barriers to such trade. GATS applies to all services ranging from transport to health and education, to banking and telecommunications. It operates through four modes of supply: Table 1 below indicates the different modes of supply under GATS. The modes of supply are a new concept in the international regulation of services. The lack of data is occasioned by the lack of statistics within these modes of supply (Rhagavan, 2002).

Table 1: Modes of delivery of services

Mode	Meaning	Example
Mode 1 Cross-border trade (GATS Article I.2a)	- where the trade takes place from the territory of country A into that of B	- telehealth[8] - passing of information by means of fax or e-mail
Mode 2 Consumption abroad (GATS Article I.2b)	- services consumed by nationals of country A, in the territory of country B where the service is supplied. Essentially the service is supplied to the consumer outside the territory of the country where the consumer resides	- consumers who cross borders to obtain medical treatment that might be cheaper or better than that available domestically - tourism
Mode 3 Commercial presence (GATS Article I.2c)	- where a service supplier of country A crosses the border to establish presence in country B and provide a service in country B	- establishment of a private hospital by a European company in Zambia
Mode 4 Movement of Natural Persons (GATS Article I.2d)	- applies to natural persons only, when they stay temporarily in a foreign member's territory in order to supply a service	- doctors and other medical specialists who leave their countries to temporarily provide their services in other countries

Looking at how GATS came into the WTO signals the possibility that the agenda of GATS may be contrary to its 'development friendly' intentions.[9] Hong (2000) states that GATS found its way into the WTO through intense lobbying by the US Coalition of Services Industries (USCSI). USCSI came into being in the mid-1970s when the US financial companies were faced with enormous difficulties in penetrating the heavily regulated Southeast Asian financial market. They found the inclusion of trade in services in GATT as the only available tool to make a break into these markets. USCSI lobbied the US private sector and they achieved their goal at the conclusion of the Uruguay Round in 1994 and GATS became operational on 1 January 1995.

Even though they did not immediately succeed in having the financial sector included in GATS, 1997 was a breakthrough for them because the European financial community had also joined them (Wesselius, January 2003). The reciprocal concessions that were granted by the developed world to developing countries in exchange for their signature on GATS and TRIPs was that increased market access would be granted for their textiles and agricultural products. This increased access for developing countries has not materialised, making a mockery of another of the fundamental principles of the WTO, reciprocity (Rhagavan, 2002). From a perspective of fairness the agreements can be regarded as having been concluded in bad faith.

The World Bank estimates that developing countries lose about US$20 billion a year just from subsidies that the EU and the US give to their farmers (Oxfam, 2002). This results in underproduction in Africa and countries in the region have serious problems with under-nourishment. Mozambique and Zambia for instance have 58% and 45% of their population undernourished respectively. This is serious deprivation with many negative health implications (Oxfam, 2002). Labonte (2002) on UNCTAD states that developing countries lose US$700 billion from the double standard applied by the developed countries.

The flexibilities that could be more development friendly in GATS are being sidelined with promotion of foreign direct investment and profiteering taking precedence. The primary consideration in judging health services under GATS is not their social function but the effect they have on trade in health services (Hillary, 2001). There is tremendous pressure from the developed world on Southern African governments and other developing countries, coming from developed countries (especially the EU) to make commitments in basic services sectors like health, water supply, education, electricity supply and other sectors. These are the services that have traditionally been provided under governmental authority.
Key issues to remember when reflecting on GATS:

- While regulation of goods under GATT was concerned with mainly border control measures like tariffs, GATS is concerned with the domestic (internal) regulation of services and service supply.
- The principles of international non-discrimination, namely most favoured nation treatment and national treatment, are useful concepts in trade in goods but are both inappropriate and inadequate in dealing with services because GATS is about regulations not tariffs. GATS creates huge uncertainties in the application of the principle of non-discrimination.
- Developing countries have virtually no surplus supply capacity and have little to gain from service liberalisation (Raghavan, 2002; Mashayekhi et al, 2002).
- Liberalisation under GATS, for developing countries, is virtually permanent as they lack the negotiating strength to implement any reversal of liberalisation.

[8] E-health (or telemedicine) is conducted over an open, transparent network, whereas tele-medicine and tele-health are characterised more by point-to-point information exchange. E-health also includes public health services delivered over the internet, and use of electronic networks for health management and information systems (World Health Organisation, January 2002)

[9] The GATS is typically presented as bringing a private sector supplier to resolve the inefficiencies of the public sector. This is not always true. Further some third world commentators have criticised the lack of a developmental agenda within the GATS (see Mashayekhi et al, 2002).

- There is no empirical data supporting the liberalisation of trade in services and none is forthcoming despite undertakings to developing countries. The impact of services trade liberalisation cannot be easily measured.

GATS main obligations

Obligations under GATS fall under two main categories: general obligations that apply across the board to all services (committed or non-committed sectors), and specific obligations that apply specifically to committed sectors only. Tables 2 (on page 30) and 3 (on pages 31-36) include the horizontal commitments of southern African states and extracts of the specific commitments, respectively. GATS applies to all levels of government and even to non-governmental organisations exercising governmental authority (Sexton, 2001).

General obligations

Two GATS obligations apply directly and automatically to all WTO members for all services – most-favoured-nation treatment and transparency. Table 4 provides a summary of GATS obligations, opportunities, threats and policy considerations.

Most favoured nation (MFN) treatment (GATS Article II) does not mean one country is preferred over another – it means the opposite. Favour one, favour all. Treat all countries the same. If a country gives a sweet to another country, it must give sweets to all other countries that are members of the WTO. If a WTO member country grants favourable treatment to another country (even a non-WTO member) regarding the import of a service, it must grant all other WTO signatories the same treatment. If a country allows any foreign competition in a service sector, it must allow service providers from all WTO member countries to compete to supply that service.

A country could list any exemptions to this MFN principle by 1995, but exemptions were to be reviewed after five years and could not last more than ten years anyway. However a dispute still persists regarding the longevity of the MFN exemptions. The WTO interprets this MFN obligation as prohibiting not only *de jure* discrimination (discrimination specifically set out in regulations) but also de facto discrimination (discrimination resulting from regulations or measures not formally discriminatory).[10]

Transparency (GATS Article III) requires governments to publish all relevant laws and regulations governing all service sectors, make them available publicly if they relate to or affect GATS and inform the Council on Trade in Services annually. Countries also have duty to respond to requests for information by other countries. By 1997 governments should have set up enquiry points for foreign companies and governments to obtain this information.

Economic integration (GATS Article V), like GATT, allows countries to enter into regional trading arrangements. Regional Trade Agreements (RTAs) allow countries to come together and share a trading arrangement that allows them to discriminate against countries that are not a part of the RTA. Members of the RTA are given more favourable treatment amongst each other and it excludes non-members. Countries often enter in RTAs to improve their bargaining power and to improve the level and quality of trade between them.

Domestic regulation (GATS Article VI) has disciplines that govern the process of review of administrative decisions and for the authorisation for the supply of a service; qualifications, standards and licensing and the recognition criteria (technical or otherwise) for service suppliers. As a general obligation these governing disciplines should be based on 'objective and transparent criteria' and should not be 'more burdensome than necessary'. Any regulation should not provide 'unnecessary barriers to trade in services'. These terms are similar to those included in other WTO agreements and they have been given particular meanings by the DSB. If a member has made

[10] The DSB is entitled to hear nullification and impairment claims from members.

specific commitments in a sector (as outlined below) it should also ensure that subsequent regulations could have been reasonably expected at the time the commitment was made. Regulation of specific sector commitments will also be looked at in the light of conformity with international standards maintained by relevant international organisations.

Monopolies and exclusive service providers (Article VIII), requires governments to ensure that there is control over the behaviour of monopolies or exclusive service suppliers. This includes situations where governments control the number of hospitals in an area by issuing a limited number of licenses (as they do in South Africa) or restricts forensic pathology services to state laboratories by giving exclusive rights. The state must ensure that the monopoly service supplier does not act in an inconsistent manner with most favoured nation treatment and specific commitment obligations, nor should it abuse its monopoly position in areas where specific obligations have been entered into. A state also cannot create new monopolies or exclusive service providers, where full commitments have been entered into.

Specific obligations

The other two GATS obligations are market access and national treatment, which apply only to those services that a country lists in its Schedule of Specific Commitments.

The **schedule of specific commitments** of a country will indicate the mode of supply that is being liberalised and the sector or subsector that is being referred to. Horizontal commitments apply to all sectors across all modes of supply. The word 'unbound' means that the country has entered into no commitments on that sector and/or mode of supply. The term 'none' means that no limitations are placed on that service sector for foreign supply of the service in that sector and/or mode of supply, in other words full liberalisation commitments have been made. Any other text is the country's restrictions that have been applied to the service and it should describe the scope of the limitations placed. Table 5 (on page 39) explains how to read a schedule and provides some examples.

Market access (GATS Article XVI) allows foreign companies to provide cross-border services in a country. Countries are free to place whatever limitations they like on specific obligations. If no restrictions are entered into the schedule then member states cannot restrict market access by limiting the number of suppliers, operations or employees in a specific sector; the value of transactions or assets; the legal form of the supplier (for instance, limiting it to a branch or joint venture); or the participation of foreign capital. Market access is granted by stating the extent of the obligation that members have in their schedule of commitments.

National treatment (GATS Article XVII) means that once foreign companies have been permitted to enter a country, they must be treated in the same way as domestic ones. The meaning of national treatment in GATS is very wide. The treatment given to a foreign service supplier can be, 'formally identical or formally different,' if it has an effect on the competitive relations between a domestic service supplier and a foreign one. The WTO explains that 'the key requirement is to abstain from measures which are liable to modify, in law or in fact, the conditions of competition in favour of a Member's own service industry'. Thus the test for non-discrimination is whether any measure puts a foreign supplier at a disadvantage.

National treatment exemptions (Articles XVI and XVI *bis*) are available in GATS. These have, however, proven to be very limited in application under GATT and pose significant challenges under GATS. There are a number of exemption measures:

- government procurement (not for commercial purposes)
- necessary to protect public morals or maintain public order
- necessary to protect human, animal or plant life
- required to maintain essential security interests.

These terms are value laden and, in other agreements, have been the cause of numerous cases before the DSB. There are other exemptions from obligations like Emergency Safeguard (Article X), which are utilised when a country experiences balance of payments difficulties.

Provision of health services under GATS

GATS schedules list several categories of health-related services divided into three areas: professional services (medical, dental, veterinary, nursing and midwifery, laboratory services, GATS sectoral classification 1Ah); *health-related and social services* (hospital, other health, social, community care including care of the elderly, GATS sectoral classification 8); and financial services (health and pensions insurance, GATS sectoral classification 7). Many countries did not realise that liberalising their financial services also meant liberalising their medical aid or insurance as well.

However, public health services fall under government authority and this is where fears arise when we look at the provision of such services under GATS. GATS lacks clarity on many issues, which makes it difficult for developing countries to stand up for their people's basic rights when faced with powerful trading partners like the EU. The typical example is found in the first article of GATS, which specifically excludes from scope, '*services supplied in the exercise of governmental authority*'. However, the same article goes on to define such a service as one '*which is supplied neither on a commercial basis, nor in competition with one or more service suppliers*'. The precise meaning of the underlined terms is not known and the meaning given will be decided upon by the Ministerial Conference, the General Council or extra-mandatorily the DSB.

In most countries, public provision of services like health and education coexists with private sector provision. The presence of private providers or application of user fees/ cost recovery means that, in such cases, public health services are covered by GATS. All general obligations have to be complied with, namely, most favoured nation (MFN) treatment, transparency, domestic regulation and the monopolies and exclusive service providers disciplines. Traditionally, health services used to be under the provision of government authority, but since the structural adjustment programmes (SAPs), they are now being provided by private corporations too. Since they now fall under GATS, they will be treated as commercial commodities instead of basic entitlements. The government cannot prevent other business players from providing these services. If it cannot compete, it has to leave the provision of these services to the competent corporations. People who can afford to will pay for the service, those who cannot, will have to do without it. Some of the threats of GATS to provision of public health are outlined below.

Commitments entered into by southern African Countries

Between Botswana, Malawi, Swaziland, Zambia and South Africa most aspects of health service provision have been fully liberalised by indicating 'none' in the schedules for market access and national treatment for professional services. This means that these countries do not place any restrictions on foreign service suppliers in the domestic market. Restrictions, for instance on the number of hospitals in a city or province are not valid because they would violate market access rules. Market access rules require that a member state does not restrict market access by limiting the number of suppliers, operations or employees in a specific sector; the value of transactions or assets; the legal form of the supplier (for instance, limiting it to a branch or joint venture); or the participation of foreign capital. Inscribing 'none' under national treatment means if the foreigner supplier faces a competitive disadvantage, the host state will treat a foreign supplier more favourably than a domestic supplier to redress this imbalance.

South Africa and Botswana put some restrictions in place on modes 1, 2 and 4, however commercial presence (mode 3) is not restricted at all. In so far as the level of commitments entered into by Malawi and Zambia go, they are the most liberal. These countries have made it most attractive for foreign service suppliers by not placing any national treatment or market

access limitations. The regulatory power of the state has been limited because there are a number of policy options that it can no longer pursue. Botswana, Malawi, Swaziland, Zambia and South Africa have without a doubt limited their policy flexibility to a large degree and will have to develop alternative means to deliver on public health goals.

The prospect of regulating healthcare effectively in southern Africa has been severely compromised, simply by making certain state acts illegal, without even larger countries like South Africa realising what they have done. Reducing policy options, or regulatory options, when the financial sustainability of the health system is uncertain may prevent effective state interventions when these are needed most. Should these 'health liberal' countries be unable or unwilling to reverse the commitments they have made then the policy recommendations in this paper will have limited relevance to them as they operate only within GATS parameters as described above and in their schedules.

The other countries like Zimbabwe, Angola and Mozambique will have far greater options in pursuing public health goals. But since these countries belong to SADC and other RTAs they will effectively allow foreign service suppliers into their markets if any of the RTA states has a substantial foreign service provider. 'Health liberal' countries, like South Africa and Zambia, will allow foreigners to enter their territories. These foreign suppliers will be given preferential access under the RTA and will creep in as a South African or Zambian entity. Even if a country does not liberalise health services with a view to protecting its health policy goals, any RTA partner that does so, will allow foreign penetration of their market. They will have to grant the RTAs favourable treatment terms to a foreign service supplier. To combat this, rules equivalent to 'rules of origin' in goods trade are required for services trade.

GATS threats to the provision of Public Health

Privatisation of public healthcare using GATS

In the forerun to Doha, civil society organisations (CSOs) had launched a campaign named 'Our World is Not For Sale'. This campaign raised the same issues presented to the Council for Trade in Services[11] by developing countries, but in addition to that, it condemned the inclusion of basic services such as water, energy supply, education and health, under GATS. On the other hand, the developed countries and the WTO Secretariat insisted that there was no threat to all services under governmental authority, because governments could limit their schedule of commitments in any way they pleased. Naturally, nothing relating to the fears of the CSOs appeared in the Services paragraph of the Doha Declaration (paragraph 15). Instead, this paragraph set deadlines for submission of initial requests and offers by trading partners.[12]

The requests to some Southern African countries, by developed countries now prove that the alarms raised by the CSOs could be correct. Health requests are expected to be made in the request and offer stage of the negotiations. Since many southern African countries have already liberalised health, few further requests are expected. Even though these countries have not yet responded to the requests, developed countries are already guaranteed of getting this particular sector through privatisation or previously privatised entitites.[13] The fall in the efficiency in the provision of public services in many developing countries, the silence of paragraph 15 of the Doha declaration on assessment, and the threat of public services, was a blessing to the corporate-led agenda of the developed countries. Many southern African governments are publicly expressing their failure to efficiently run state monopolies that have for all these years been providing basic services to their nations. Thousands of people are dying by day without being

[11] A body established by the WTO under the GATS agreement.

[12] The Doha Paragraph 15 on Services gave cut-off dates for the submission of initial request and offer proposals by WTO Members to the Council of Trade in Services (CTS). These were pinned to 30 June 2002 for requests, and 31 March 2003 for offers.

[13] The narrow definition of the governmental exception in the GATS facilitates this.

able to access medical attention in the run-down state-owned hospitals. For example, the percentage of Zimbabweans with access to health facilities rose from 14 to 87% in 1980, thanks to a national programme to build hundreds of hospitals and clinics across the country (IRIN, August 2001). Twenty-three years down the line, the state-owned hospitals, which can be afforded by the majority poor, are run down, understaffed and have no readily available medicine; user-fees have increased enormously, and prices of drugs (if found in the local pharmacies) have gone up by more than 200%. Infant mortality has risen by a quarter in Zambia since 1980, while life expectancy has dropped from 54 years to 40 (Sexton, 2001).

There is no doubt, developing country governments are under enormous pressure to privatise services. User fees and privatisation form an integral part of aid packages (Bond et al, 2003). GATS does not promote privatisation of services itself. However, its limited governmental exception makes government services subject to GATS disciplines.

Privatisation of healthcare without regard to accessibility combined with the pressure to reduce public spending especially in health, can have adverse effect on human development (Bond et al, 2003). The introduction of user fees and price increases in health services, through cost recovery programmes, resulted in a decline in the use of medical services in countries such as Ghana, Kenya and Nigeria, resulting in an increase in child mortality and some diseases (South Centre, December 2002; Gilson, 1997). Gilson (1997) stated that fees 'dissuade the poor more than the rich from using health services'. In South Africa, for example, in mid-2000, the provincial government in KwaZulu-Natal began charging rural residents for water that used to be free (a R10 connection fee and/or volumetric charges). Thousands of poor households could not afford these costs and began using nearby rivers and stagnant ponds. Within weeks, cholera broke out and claimed more than 250 lives. It costs the South African government more to deal with the cholera crisis than it did to provide free water. To give some sense of the scale of the problem, some 43,000 people (mostly black children under the age of five) die from diarrhoea-related illnesses in South Africa every year, and total cases number 24 million. Direct medical costs for all of these are R3.4 billion, with broader losses in economic production totalling another R26 billion. To supply proper water and sanitation to everybody in the country would cost less than two-thirds of that. (Mackintosh, 2001).

Health financing

In southern Africa public healthcare is still heavily subsidised by governments. This selective subsidisation, no matter how modest, could become a thing of the past if southern African governments commit their health services under GATS. Through the national treatment clause, governments will not be able to differentiate private health service providers from public providers as before.[14] Subsidies will be available to the TNCs as well, even if they do not need them at all. Essentially, public funds could be directed for use in the private sector, effectively resulting in public subsidising of private sector profits. In Zimbabwe there are a number of direct and structural subsidies that benefit the private sector (Mudyarabikwa, 2000). With the wide application of GATS and increased privatisation, it is likely that more public resources will be directed to the private sector. This is problematic given the lower levels of access and efficiency in private providers of services (Cleary, 2002).

The use of cross-subsidisation will also be threatened. Money for cross subsidisation is usually generated by a monopoly or exclusive service provider.[15] The monopoly power or exclusivity is used to charge higher than normal rates to some users and fund users who cannot afford the service. Under this principle, areas or services that cost less subsidise areas and services that cost more. In many countries, profitable services such as international telephone calls have subsidised less profitable but socially beneficial telephone services in rural areas. In transport, bus services or railway branch lines serving outlying areas are easily paid for by routes in busy, more

[14] Unless this limitation is listed in the members schedule.
[15] Unlisted or new monopolies and exclusive service providers are prohibited under the GATS.

congested areas. Risk pooling and cross subsidies between rich and poor, healthy and sick ensure that all get tolerably equal access to similar levels of care because the basis of public services aims to be redistribution. Getting rid of cross-subsidisation allows corporations to divide up integrated healthcare services, extract the more profitable ones and the more profitable patients (usually those who least need healthcare) and leave behind a higher risk pool to the (SAPs) reduced public sector. Such break-ups threaten the principles of universal coverage and shared risk that tax-funded (as in Britain and Canada) or social-insurance-funded (as in France or Germany) healthcare systems generally uphold (Sexton, 2001).

Regulatory framework: domestic regulation

Citizen groups are concerned that GATS is creating conditions that may ultimately affect the public's access to healthcare. Among the concerns is that governments would come under pressure to change the conditions under which public services are provided. Regulation is the key policy and intervention tool that governments have to influence health policy goals. Many writers critical of GATS have been criticised by the WTO for creating scare and horror stories to sensationalise the impact of GATS. The rules of interpretation applicable to GATS (combined with policy coherence of the international finance institutions) do not preclude these scary interpretations. GATS is the law regulating services trade. As such the law must be understood postivistically – the law is only what it says it is, no more, no less.

Under GATS (Article VI.4), the WTO is mandated to develop 'necessary disciplines' to ensure that *'measures relating to qualification requirements and procedures, technical standards and licensing requirements do not constitute unnecessary barriers to trade'.* Targeted for disciplining are government regulatory measures that can fall under the broad categories of qualification requirements, technical standards and licensing requirements, which affect any service sectors, not only those in which countries have made commitments. Under the proposed new disciplines, governments may be required to show that the regulations are necessary to achieve an objective that is held to be 'legitimate' by the WTO (a 'necessity test'); and that it was not possible to adopt a less commercially restrictive alternative measure. The proposed disciplines, if adopted, can be expected to significantly constrain governments from exercising their authority to regulate some aspects of services (Third World Network, December 2001). Most southern African countries for instance, have regulations that control the sale of alcohol to minors. Should international distributors have problems entering these alcohol markets they could launch a challenge against the labelling or other control measures as these are competent challenges under GATS. Crutsinger (2003) reports on US concerns about EU proposals in negotiations to remove barriers to trade, exclusive providers, in the distribution of liquor. The EU proposal is a legitimate GATS demand.

The power of governments to determine domestic policy is under threat through GATS. Through GATS Article VI.4, the flexibility of policy makers to achieve legitimate policy objectives for the good of their people might be constrained (Rhagavan, 2001). Making commitments in health services might be meaningful, to a certain extent, if governments do not lose their ability to regulate economic activity and to provide basic affordable and accessible health services to all their people. Advocates of GATS argue that GATS Article VI.4 on Domestic Regulation permits governments to protect their basic services. However, the article on domestic regulation takes a minimalist view on the kinds of regulations that should cover services. GATS is represented by the wording of the text itself and must be read in this way. What GATS is and what GATS says is the basis for interpretation.

Article VI states that disciplines relating to qualifications, procedures, licensing and technical standards should be '*no more burdensome than necessary to ensure the quality of the service*'. However, '*the quality of the service*' does not address the critical question of access to and distribution of services. In the absence of regulation it may leave poor populations extremely

[16] See Table 1.

vulnerable to neglect, as key public services, such as health services, are privatised. Health priorities, in principle, cannot and should not be made subject only to trade concerns. There is also no criterion for determining '*more burdensome than necessary*'. The ambiguities leave a given country's regulations to ensure universal and affordable healthcare, for example, open to the WTO dispute settlement mechanisms. What this Article VI actually mandates is that, government regulation is permitted as long as it does not constitute an unnecessary barrier to trade. However, it is unconscionable to treat non-essential entertainment services and essential health services in the same manner as the DSB is wont to do. Table 6 (pages 39-41) lists the key definitional challenges that GATS raises. A cursory overview shows that the degree of certainty provided to regulators is low.

The definitional gap and challenge is linked to the problem of the DSB exceeding its mandate to make substantive interpretations of the texts. Words such as necessary and burdensome involve value judgements that are not only trade related, but relate to the fundamental processes of distribution in an economy. Regulations produce regulatory rents that need to be assigned in society. Regulatory rents refer to the benefits that stakeholders receive directly because of the effect of the regulations. By regulating the provision of services and service suppliers, governments are able to influence service delivery so that even marginalised and poor groups can get a share of these regulatory rents. These decisions are not for a court or dispute panel to make, they are value judgements that should be left to democratically elected institutions to make. The DSB cannot replace democratically elected national institutions and make decisions about the appropriateness or necessity of regulations governing services.

The essential problem with GATS remains: how does one pass a trade restrictive measure that is legitimate and necessary (Trachtman, 1995). There seems to be very limited scope in GATS to do so. What is legitimate and necessary in one state could be very different in another. This creates an unprecedented level of uncertainty in the WTO legal validity of most domestic regulations. The meanings of the words in GATS are value laden terms and are very imprecise. The purpose of legal agreements is to provide legal certainty in unregulated areas of international interaction. GATS does precisely the opposite. It is not clear what level of scrutiny or 'margin of appreciation' the DSB will give to the meaning of the word 'necessary'. A necessity test can be applied in a wide sense, giving national governments greater scope to regulate services; or it can be applied in a narrow sense, restricting the power of national governments to maintain or develop new regulations for services.

Scope of the governmental exception

At a meeting of the Council for Trade in Services it was agreed that 'exceptions in Article I:3 needed to be interpreted narrowly'. Narrow means that most government services will be covered by GATS and excluded from the exception (Gould et al, 2002).

Where government services are either provided on a commercial basis or in competition with other service suppliers, GATS will apply (Krajewski, 2002). In effect, there is no exclusion of public services from GATS. The meaning of commercial can be exchange of goods with or without the intention of making a profit. This means that any buying or selling (or user fees) of services will be covered by GATS. Competition means that at least two producers target the same market. This means they provide similar services to consumers. However, it will not be easy to determine similar services or consumers.

Governments will therefore have to comply with their general obligations – such as most favoured nation treatment; the prohibition on abusive monopoly behaviour (if there are market access restrictions); the duty to respond to queries about regulations and policies – and their specific obligations. From this we can deduce that the provisions of GATS will cover all public service hospitals.

In the WTO's 2001 'GATS – Fact and Fiction' it states that many public services are not provided on a commercial or competitive basis, and it excludes services provided in the exercise of government authority. It goes on to add that members have not expressed a need to adopt an authoritative interpretation of these terms but can do so when desired. The WTO promptly adds that those services provided on a commercial or competitive basis are covered by GATS. The WTO relies on the freedom of the member to include or exclude a sector from their GATS schedule. This view is only tenable if one treats members of the WTO as formally equal, when in fact they have unequal bargaining powers. In short, even by the WTO's own admission, the governmental exception in GATS is narrow.

Further, WTO states that members are free to regulate their domestic markets, and later adds that: 'the only circumstance in which a country will be asked to demonstrate that a … measure is not more trade restrictive than necessary would be in the event of a dispute… only then could the necessity or trade restrictiveness of a measure become an issue.' (WTO, 2001b, p.11). Simply, a member is free to regulate their markets in any way they like until a dispute is raised and a decision is made by the DSB. The WTO itself reinforces the interpretation of domestic regulation given in this paper, since it cannot deviate from the text of GATS itself.

Monopolies and exclusive service providers

The restrictions on monopoly or exclusive service suppliers, where no specific obligations have been entered into, are a clear indication of the 'one size fits all' approach of the WTO. Monopoly or exclusive service suppliers in developing countries could use their monopoly powers in stimulating the domestic economy by developing new or more diverse areas of service delivery or improve service quality. Developed countries are dominated by large TNCs and corporates who have economies of scale, capital and know how to enter foreign markets and displace domestic monopolies. Institutions originating in developing countries do not have a positive global reach. GATS facilitates this displacement of local for foreign in the name of competition. The irony in this is that a country would merely be displacing a domestic monopoly owner for a global monopoly or cartel, since globally health provision is dominated by a few suppliers (Hillary, 2002). Monopolies and exclusive service providers are viable vehicles for utilising and implementing the principle of cross subsidisation. Cross subsidisation can improve health equity by using monopoly profits to fund other services that target the poor. In addition, in capital-scarce developing countries, this will prevent the over-capitalisation in highly serviced areas, thereby reducing the amount of resources for investment in more needy areas. South Africa regulates the amount of hospitals in an area by limiting the number of licenses it is prepared to grant in geographical areas even to the private sector (Cleary, 2000).

Economic integration

Economic integration and Regional Trade agreements (RTAs) are exceptions to the rules of non-discrimination that govern international trade at the WTO. Economic integration allows countries to have better and more preferential relationships with particular countries. In this way, RTAs offer members the opportunity of integrating their economies amongst each other thereby stimulating development and intra-regional trade. The European Union is an example of an RTA, in the same way NAFTA is within the Americas.

The RTA exception is also found in GATT and GATS in many ways mirrors the GATT prescription. However, there is a notable difference in GATS RTA exemption, which has been named the Trojan Horse. Article V.6 of GATS allows for a wholly owned foreign company, which is merely incorporated within the territory of a member of the RTA, and conducts 'substantial business operations' in the territory, to be entitled to the preferential treatment granted by the RTA. This means that restrictions that one member makes on commercial presence and on the amount of foreign ownership in an entity can easily be bypassed. Foreign companies will be able to abuse RTAs by cloaking their foreign ownership through local incorporation of their enterprises, thereby nullifying the purpose of the RTA. RTAs are no defence against foreign penetration of markets and may undermine the development of complementarities within a region

The implications for health services are that it will be difficult to retain domestic control over health services as preferential treatment will have to be granted to non-RTA state service providers. Domestic ownership and control over health services will be reduced and regional integration will be undermined because of non-regional participation. The implication is that southern Africa will be increasingly dependent on the rest of the world and may crowd out its regional counterparts, instead of having a greater regional dependency.

Transparency

While transparency may seem to be a reasonable request, it places an enormous burden on African countries in which resources are scarce and where resources can be better deployed in more productive areas. This is another instance where a seemingly neutral clause in GATS has a disproportionate effect on developing countries. Developing countries will have to spend more on ensuring compliance with the GATS requirements instead of their normal national processes for ensuring transparency.

Market access and domestic regulation

Where market access commitments have been made, it does not matter whether domestic regulations in a country are discriminatory or not (Gould, 2002). All regulations have to facilitate market access by complying with the requirements of domestic regulations in article VI. This means regulations must not be unnecessary barriers to trade, no more burdensome than necessary and for new regulations they must have been contemplated at the time of entering the commitment. Market access can therefore be viewed as the equivalent of the elimination of quantitative restrictions in goods trade.

If full market access commitments are made, it means that governments cannot control the number of hospitals in a region. This means that in urban areas where there are lucrative markets for health services, many hospitals will be invested in and built and rural and less populated areas will suffer from a lack of investment. In capital-scarce developing countries this will lead to intense competition in urban areas, which may become over serviced, crowding out any investment potential in the rural areas. Health access will then be linked directly to profitability only and its social value will be undermined. There is a need for developing countries to maintain control over the investments made in health service provision so that capital investments are sustainable and meet the needs of the citizenry.

Domestic regulations for water, electricity and education are subject to the same challenges under GATS. Anti-equity provisions in any of these sectors can be locked in by precedent (at the DSB and domestically) for the evaluation of GATS disputes.

National treatment and domestic regulation

National treatment as a legal concept in the GATS agreement is very imprecise. It requires that foreign service suppliers should be given treatment that can be formally equal or formally unequal from that given to domestic service suppliers. This means that in some instances a foreign service supplier can be treated exactly the same as a domestic supplier (i.e. equality). Or it can mean that a foreign service supplier can be treated differently from the domestic service supplier, if the regulations or conditions of competition favour the domestic supplier (i.e. equity). In effect, it means that governments will be obligated, in the name of competition, to relax regulations or favour foreign service suppliers in other ways.

In South Africa, a policy of affirmative action is legislated to promote the employment of blacks, women and people with disabilities. A foreign service supplier could be entitled to claim that this regulation be relaxed in its favour as domestic service suppliers who are already established in the market have an unfair competitive advantage (Steytler, 1999). If for example, there are building regulations that require theatres to have individual circuit breakers (fuses) for appliances and this proves too onerous for a foreign service supplier (because of differing international standards or financial costs), it could make a case for not complying with these regulations.

Differential regulation of foreign and local service suppliers will burden the capacity of already under-resourced inspection agencies. Furthermore, differential regulation will encourage domestic companies to externalise their operations so that they may also benefit from the relaxed regulations, since it is relatively easy to externalise operations in today's commercial environment. National treatment and domestic regulation therefore actually act as a disincentive for the promotion and development of local service suppliers.

Perfectly legitimate and valid regulations can be challenged. The effect is that when regulations are changed, the regulatory rents that were created are redirected for the benefit of the foreign service supplier instead of the intended beneficiaries. The real problem with the concept of national treatment is that there is no real definition of what a level competitive terrain actually is (Trachtman, 1995). This means that it is not possible to evaluate whether the relaxation of any domestic regulations or facilitation of international service suppliers market access actually meets the standard of equalising competition. The dangerous assumption that is made is that current regulations are able to meet the demands of GATS, are able to regulate the behaviour of foreign service providers and do not require further refinement or amendment. This assumption is not necessarily true as the regulation of affirmative action in South Africa clearly evidences.

GATS allows objective and transparent criteria to protect consumers and the public in the form of recognition of qualifications and meeting technical standards (GATS article VI.4). Countries can set benchmarks for recognition in order to protect service provision in a market. It should be borne in mind that these benchmarks cannot be restrictions to trade in services themselves.

Exemptions and the irreversible nature of GATS commitments

The exemptions in GATS are notoriously narrow. The meanings given to the word 'necessary' has been interpreted by the DSB as being understood only within a trade context. Trade-related issues are not the only concerns that are taken into account when regulations are made. The exemptions therefore do not provide protection based on the full spectrum of human rights concerns nor for the rights and duties that states have to the citizens and to the international community. For instance the EU/US beef hormones case referred to on page 15.

GATS commitments are 'irreversible', regardless of changes of government. The term *irreversible* is in quotes because there are some articles of GATS that allow for reversibility of commitments, but their implementation is problematic to most developing countries. GATS allows members to renegotiate their commitments against compensation (GATS Article XXI), ignore them for health and other public policy reasons (GATS Article XIV) or security concerns (GATS Article XVI *bis*), and introduce restrictions to protect the Balance of Payments (GATS Article XII). While these provisions seem to give some flexibility on government commitments, they remain impossible to implement because developing country governments would not have the financial capacity to meet the compensation that might be required. Furthermore, renegotiating commitments might mean putting under threat some of the unopened sectors. The most difficult thing for developing countries will be for them to prove that the negative impact (prompting them to reverse their commitments) is solely due to the liberalisation of the particular service sector. The losing country can take the country seeking to reverse its commitments, to the Dispute Settlement Body. This will make it unaffordable for developing countries. So, in the end, developing countries maintain their commitments.

Where developing countries have liberalised a number of their service sectors under SAPs but not done so under GATS, the only GATS obligations that these liberalised sectors would attract would be the general obligations. This provides greater latitude for reversibility than if commitments had been made in these sectors under GATS.

For example Zambia, which committed its health services under GATS in 1995[16], is currently undergoing a revision of its Investment Act and submissions are being received from the public

on what they feel should go into the Act. In this regard Zambia has encountered a number of hitches, as most of the submissions, if accepted, will contradict its schedule of commitments in its current form. For example, some of the submissions border on joint venture conditions for foreign investment and setting aside of certain sub-sectors for locals. Accepting such conditions would mean, as stipulated in GATS, renegotiating its schedule with other WTO members. The WTO Secretariat has informed Zambia that *'no country has so far gone through the renegotiation process and it would be a complex issue for Zambia to go through.'* In other words, the WTO Secretariat is warning Zambia not to tamper with its commitments. So despite demands from its citizenry that Zambia acts in their interest, Zambia is virtually forbidden from doing so. The consequences of this limited flexibility can lead to serious political instability, a concern that is not shared by the WTO.

South Africa has conducted consultations with domestic service suppliers with regard to export capacity and barriers. Calls for views from the public are also intermittently made. However, the central driving principle behind consultations in South Africa has been identifying areas of export interest for local firms. In South Africa the Department of Trade and Industry deals with GATS requests and offers. From discussions with individuals within Trade and Industry the impression is that service sectors handled by other departments are not really aware of the implications of GATS agreement. Still they said that the key driving force was the Ministry of Trade and Industry.

Threat of sanctions

Being a member of the WTO means that a country must subscribe to all the multilateral agreements of the WTO. When a country is found to be violating any one of the agreements it can be taken to the DSB who can then make a ruling. If a ruling is made in favour of a complaining country, that country may impose sanctions. The sanctions it can impose can be based on the agreement that caused the dispute or it can be on any of the other agreements of the WTO. For instance, if a country is found to be violating the TRIPS agreement, sanctions can be imposed on it in the area of services trade or goods trade. The result is that a dispute in any one area can result in sanctions being imposed on any of the WTO regulated agreements. Essentially, this means that none of the agreements can be viewed in isolation of one another and punishment follows on any violation in any area. Links between agreements, such as between GATS and TRIPS, are summarised in Table 7 (on page 42).

Generic procurement and domestic production of pharmaceuticals

Some governments have specific regulations for the use of generic drugs. Generic drugs are copies of patented drugs (or drugs on which the patents have expired) and are often cheaper. Governments support the policy of prescribing generic rather than patent/brand names because it stretches their available resources by making more cost-effective usage of drugs. Mozambique currently pursues this policy. If specific commitments are entered into on health then, domestic regulation disciplines in GATS may well create the potential for patent holders to challenge regulations promoting generics as unnecessarily trade restrictive or more burdensome than necessary, and therefore illegal. A challenge was successfully made under NAFTA against Canada on this basis because it imposed quantitative restriction on the market by promoting the prescription of drugs by generic names instead of by brand name (Hillary, 2001).

The Doha declaration (erroneously called the 'Development Round') clarified the rights of members to use compulsory licensing for parallel importation or domestic manufacture of patented drugs. By including this provision in the TRIPS agreement it was envisaged that it would help alleviate the scarcity of access to technology that TRIPS would create. Developing countries are allowed to license a patented drug and produce it predominantly for domestic consumption. Any excess may be exported but production must be mainly for the local market (i.e. 51%). To take advantage of the space provided for in TRIPS, developing countries will have to create pharmaceutical manufacturers so that they can prevent millions of imminently

preventable deaths in Africa. African countries purchase relatively few drugs because of the lack of budget and because of the prohibitive prices charged for patented drugs. The ability to purchase drugs will limit the viability of a domestic pharmaceutical plant, unless it is state sponsored or enjoys some kind of monopoly or exclusivity.

The advantage of domestic production (and supply capacity) will limit the need to generate foreign exchange and supplies may even be maintained when there are balance of payments difficulties, ensuring continuity of supply. Developing countries can link with each other to invest in different production capacities for different drugs, thereby expanding their access to drugs they cannot produce and creating export markets for their products. Governments will also have to play a critical role in ensuring the success of these enterprises (whether public or private) by creating markets domestically by showing a preference for locally produced drugs (not just for export) and generating economies of scale. If health services (and related services like wholesale and retail distribution) are committed under GATS without ensuring that domestic generic production of drugs is supported by clear and explicit policies and regulations, developing countries may not be able to take full advantage of TRIPS and the Doha Declaration. By implication, this means that when health sectors are committed, wide language must describe the right to establish and support domestic producers of drugs and their international counterparts who supplement their product range. Members must retain the right to regulate on the use of generics and to introduce or grant monopoly or exclusive rights to drug suppliers irrespective of where they inter-link with the services sector.

Government procurement and governmental exemption

If a government purchases goods or services not for commercial use then those goods or services are excluded from the scope and authority of the WTO agreements. Governments therefore have absolute authority to determine how they procure services and what conditions they attach to the procurement of the service according to Article VIII (Third World Network, 2003).

However, the application of GATS to government services is a lot more restrictive and is covered more fully above. Government services that are provided in competition with other service providers, like private hospitals, or on a commercial basis, receiving fees for services, are covered by GATS. If there is a complete or substantial privatisation of the provision of healthcare services in a country, then it will be very difficult for government to use its procurement powers as it will not have a readily available distribution network for the drugs. In this case it will have to subsidise private healthcare providers to assist with the distribution of these drugs. Distribution via the private sector is prone to a number of problems and will pose a number of challenges regarding accountability and transparency.

Where a country has made commitments in health but retains market access restrictions, then any use of its governmental procurement powers (for instance, procurement through compulsory licensing) may amount to a favouring of a public provider of a service because of the purchasing power of the public health service. With market access limitations (such as restrictions on the number of hospitals in a region), this may be a breach of the national treatment principle because it favours a domestic public service supplier over foreign service suppliers. The public hospital dispensing these drugs may be called upon to charge market-related prices for the drugs to fee-paying clients and be constrained from using its procurement power to become more attractive to fee-paying clients. National treatment requires that the terrain of competition should not favour domestic suppliers over foreign suppliers. Public providers may be prevented from using their monopoly power to cross subsidise other areas of their services and it reduces their policy flexibility to attract more fee-paying clients into the public service, depending on the type of commitments entered into.

Limitation of distribution networks

Not all services covered by GATS have been classified and substantial room exists for the development of further classifications (Sexton, 2001). Since many productive activities use a number of services simultaneously, there are important linkages between the various service sectors and the goods sector. For instance, a hospital may provide healthcare but it may also use professional/business services to assist it with managing the hospital and to provide transport services to secure deliveries.

A service is defined not with reference to the type of institution making use of the service but on the nature of the activity. If the nature of the activity is a service then it will be covered by GATS. For example, pharmaceutical products (many are regulated by TRIPS agreement) are goods that hospitals use on a regular basis. Pharmaceutical products need to travel through a distribution network from the manufacturer or importer to the hospital. If commitments are entered into in the transport, wholesale and retail distribution services sector then a hospital's access to these products will also be governed by GATS because they are accessing a service from another sector that also shares GATS obligations. So if commitments are made in the health, transport and the wholesale and retail distribution sectors, preferences that are given to local transporters, wholesalers or retailers (to stimulate local economic development) for the supply of drugs may be deemed contrary to GATS. This applies even though the hospital is purchasing drugs, which are goods, and not services. In effect, the rights and obligations created by the WTO agreements are cumulative, that is they add to and supplement each other. Rhagavan (2002), in his commentary on the EU's bananas case, is clear that the WTO agreements are separate and distinct agreements and that countries should not face the burden of cumulative rights and obligations because they did not agree to it nor was it intended. This is another example of how the DSB exceeds its mandate by substantively interpreting the agreements and creating new obligations for countries.

Does GATS provide any opportunities for equity in health?

Proponents of GATS point to some opportunities that may arise out of the agreement. These opportunities need to be closely scrutinised to see whether they can be taken advantage of in practice.

GATS as a framework is considered to be 'development friendly'.[17] This is mostly because of two Articles of GATS (Article IV and Article XIX), which seem to give some flexibility to developing countries when they make commitments under GATS. Other positive aspects of GATS Article XIX include: provision for appropriate flexibility for individual developing country members; provision of liberalising fewer types of transactions and progressively extending market access in line with their development situation; allowing them to attach market access conditions when making their markets available to foreign service suppliers. In practice, the flexibility of these articles is undermined by pressures that developing countries face to liberalise sectors that they would ordinarily not have committed for trade and profit.

In the implementation of GATS, southern African countries and other developing countries face structural problems that hinder their ability to export services. These include barriers to market access and national treatment as well as difficulties in market entry caused by anti-competitive practices among others. Among the major supply constraints are: lack of human resources and technology to ensure professional and quality standards; weak telecommunications infrastructure; lack of national strategy for the export of services; lack of government support to help service firms – especially small and medium enterprises; weak financial capacity of firms; lack of a presence in major markets; and an inability to offer a package of services (Third World Network,

[17] The GATS is presented as a solution to the budgetary crises most public health services are experiencing. The GATS, by granting rights to foreign service providers, promises to attract the necessary resources so that users can access these services. The GATS implicitly relies on attracting FDI into the liberalised sectors.

December 2001). So, even if developed countries do make offers, to developing countries in a wide range of service sectors, these countries will not be able to access the offered markets.

Some developing countries feel that they could benefit from GATS if their developed country trading partners make reasonable commitments under mode 4. They feel that they could get remittances as well as technology/knowledge transfer, from their nationals who could get the opportunity to work abroad. This gain does not accrue where nationals (often highly skilled professionals[18]) leave and become permanent residents of host countries, with remittances back not compensating for training investment losses (Sako, 2002; EQUINET, 2003).

The inherent bias in GATS is evident under mode 4, the movement of natural persons. Services have been classified in terms of professional or technical capabilities of persons. In reality, developing countries have a surplus of unskilled persons which is not catered for directly under GATS. Manual forms of work that do not require skills and are also services, such as cleaning and mining, receive scant attention from GATS or their negotiators.

The benefits of liberalisation in terms of access to new employment possibilities, efficiency gains and dynamic innovations gains through knowledge spillovers and transfer of technology have been highlighted in several studies (Mashayekhi et al, 2002). However, these benefits are not automatic and may also entail a number of structural adjustments. A number of preconditions would need to be fulfilled, including appropriate national policies that are able to create conditions that favour the provision of services and institutional regulatory framework, meaning a regulatory authority that has the capacity to control and meaningfully influence the behaviour of various actors in service provision (Mashayekhi et al, 2002).

[18] Termed brain drain, human capital flight represents the loss of highly skilled professional from a source country to a recipient country as a result of strong attractions associated with differentials in living conditions, opportunities for professional advancement, the existence of an environment that is conducive to peace and security, among a host of other factors (Sako, 2002).

PART III: POLICY RECOMMENDATIONS AND OPTIONS

The paper indicates that the balance of concessions favours exports of services from developed countries to developing countries. If service exports of developing countries cannot be realised then participation in GATS yields very limited benefits to developing countries. It increases their need for foreign exchange to pay for foreign services and reduces their regulatory authority.

This analysis highlights the risks to health equity of developing countries entering into commitments under GATS. It indicates that a pro health equity policy option is to avoid commitments in health and health related services under GATS and wherever possible, to reverse the commitments made (Mashayekhi et al, 2002; Rhagavan, 2002).

For countries like South Africa, Malawi and Zambia who have entered commitments under their health sectors and are not obtaining the anticipated investments in health there is need for wider regional and African alliances to: strengthen bargaining positions, remove commitments that undermine public health and to prevent further commitments being made.

The primary persons involved with all aspects of GATS are trade negotiators. Trade negotiators activities have been identified in Table 8 (on page 43). Trade negotiators should liase and consult extensively with other stakeholders before making any commitments under GATS. Trade negotiators should always keep the systemic challenges in mind when negotiating GATS commitments namely, the DSB creating new rights and obligations for members, the adoption of DSB rulings and the requirement of obtaining reciprocal concessions from trading partners. There is a need to publicise GATS requests and offers for the scrutiny of the public, members of parliaments and regulatory authorities at all levels. This will help in exposing the hidden threats of GATS, especially in the provision of public healthcare. By working with CSOs, governments can develop a baseline position that they cannot cross no matter what international pressures are brought to bear on them. This will bolster their negotiating positions.

Regulators of public health charged with services delivery are the other actors identified with issues in Table 8. Regulators need to understand the broad framework that is set by GATS in order to effectively and legally regulate the provision of services. Besides service sectors, regulators include those officials in charge of intellectual property rights, competition and procurement policies. Regulators should ideally liase directly with trade negotiators as GATS focuses on regulation. Other actors are also identified, for instance accountants and officials of statistical services. The latter must ensure that data is collected so that the impact of GATS can be evaluated. GATS presents a definitional nightmare as many of its terms are value laden and do not have precise meanings. Regulators need to be aware of these gaps and need to take pre-emptive action to stop their authority from being curtailed or to protect service sectors that have not been liberalised under the GATS.

While it is advisable that no new commitments be entered into and that commitments made should be reversed, the political reality of strong foreign economic pressures on southern Africa indicates that where concessions have been made, other options should be taken into consideration as pertaining to the provision of healthcare.

GATS specific challenges

Schedules of commitments are flexible in that developing countries can include anything they would like into them, provided they can get them accepted in the negotiating process. This flexibility can and must be used. It even provides the opportunity of creating most favoured nation treatment exemptions through the back door. Any restriction of GATS powers is a gain for the national regulatory system. The national regulatory systems in southern Africa needs as much

policy flexibility as it can get because of the enormous challenges facing our societies. It is also essential that no country enters 'none' into any of its schedules (fully liberalising a sector) as it limits policy flexibility too much and creates unwarranted levels of uncertainty.

Negotiation issues

Since there is no meaningful empirical data informing GATS negotiations, developing countries should defend their position not to enter any new commitments. There is a need to carry out **detailed sectoral impact assessment of GATS** before entering into the next phase of the negotiations or at the very least to assess in parallel with on-going negotiations. Southern African countries should combine forces with other developing countries and therefore ensure that assessment stays in the Council for Trade in Services (CTS) agenda and that members remain engaged in this exercise. Members should focus on the adjustment of negotiations in light of the results of the assessment – as mandated by paragraph 14 of the Negotiating Guidelines. Members should not be content with a cursory assessment but should rather insist on a detailed report upon which they can make informed decisions rather than decisions based purely on ideological/theoretical considerations.

The practicalities of what is meant by **transparency** should be dealt with at the multilateral level and should not be dealt with in bilateral negotiations. Transparency issues should be excluded from schedules of commitments except where they are more restrictive than those included in GATS.

There is a need to **ensure the general exclusion of public services from GATS.** Southern African governments should insist on the removal of public health from GATS. This means that the understanding of GATS Article I.3 should be amended or there should be an explicit understanding of the interpretation thereof. Any interpretation of Article I.3 should make a distinction between essential services and non-essential services, as it is inappropriate to deal with health and entertainment in the same way.

Failing an amendment, developing countries should enter limitations in their schedules restricting the scope of application of GATS to these services. Developing countries can use their schedules to include definitions of particular limitations on the meanings of the words 'necessary' and 'burdensome,' under domestic regulation and the general exemptions. By adding expansive terminology to the schedules they will force the DSB to consider the actual text of the commitments rather than leaving it solely up to the DSB to interpret.

Backed up with a negotiating history, developing countries can ensure that challenges at the DSB can be vigorously defended. For example when scheduling a commitment in health services it can state that *'necessary' limitations can be introduced in the sector if they promote the domestic public health priorities identified by the Ministry of Health that are not only trade related but meet important public health goals.* This will expand the scope of the necessity test applicable to that particular country. Any foreign service supplier who invests can be presumed to understand the risk of investing with this kind of limitation and will be precluded from seeking compensation if changes are implemented that are trade restrictive.

Alternatively, developing countries can subject their scheduled commitments to changes made by governmental institutions (like regulatory bodies or legislatures), thereby incorporating the democratic processes and institutions directly into GATS. For example, changes in regulations in the health sector shall be made at the discretion of the Health Ministry taking into account the interests of domestic and foreign stakeholders.

Legal issues

Governments should **retain the right to create monopolies and exclusive service providers** prospectively if new needs or technologies arise or if cross subsidisation is necessary for the viability of the enterprise. For instance, government may want to support telemedicine by creating a monopoly service in order to establish the market if the initial investment to create such services is too onerous for private investors.

Generally, governments should retain the right to have public services subject to monopolies and exclusive service providers. The wording used by the EU is instructive: 'In all EC Member States services considered as public utilities at a national or local level may be subject to public monopolies or to exclusive rights granted to private operators.' SADC and other African countries should consider using the same or similar wordings to protect their public services.

The **regulatory powers of national policy makers should be safeguarded from domestic regulation threats** (necessity test, transparency disciplines, etc.) by including expansive definitions when committing a sector. Including the decision-making institutions (retaining their authority to make decisions and decide what are legitimate measures to pursue, like universal service obligations) into the process can also safeguard the regulatory powers. References can also be made to domestic standards-setting bodies who can be encouraged to develop local standards that will govern regulation of liberalised GATS sectors.

Regulatory powers must focus also on the restrictions for domestic firms into foreign markets. Reviews of foreign regulation is necessary to ensure that promised market access and national treatment is realised. Furthermore, without understanding the regulatory environment of a country it is impossible to trade concessions or ascribe a value to them in practical terms.

A statement to the effect that, **domestic standards** will be set for the relaxation of any regulations in favour of foreign suppliers should be included in any new scheduled commitment. The effect of this will be to curb the relaxation of regulations to equalise the terrain of competition between foreign and local service suppliers since GATS is unclear what a level terrain of competition is.

Market access and national treatment should **curb the 'lock in nature' of GATS** liberalisation by including sector specific time limitations for domestic review of commitments under GATS. This means that if any commitments are made in health or related sectors, the schedule of commitment should state that the commitment shall be subject to review or full withdrawal after, say, 5 years if there are relatively small investments made and 10 years for larger investments. There is no limitation on the type of commitments that can be scheduled and by including a domestic 'built-in' agenda for review, investors in sectors can be protected from losses because they are informed of the limitations in the sector and should tailor their investments to meet these requirements. Since reciprocity is the basis for concessions, other members are free to make their market access conditions subject to the same limitations.

Market access obligations should include expansive language in the text and not constrain policy tools (GATS Article XVI). The very terminology included in GATS could be the basis of limitations on market access. Phrases like 'economic means tests' should be included in restrictions as there is a large number of economic needs tests that can be used flexibly to produce results that are suited to the interests of a developing country, should they wish to regulate the committed sector even after a commitment has been entered. Economic needs tests under market access can be the equivalent of anti-dumping in goods trade.

In addition, market access terms can fully exclude all of Article XVI.2's limitations, which are stated in the negative. The commitment can then state in positive what type of market access is being granted. Market access as defined in the negative in the article creates too much uncertainty. By stating a commitment positively, foreign entrants will have greater clarity without compromising the regulatory role of the host state.

There is a need to strengthen institutional and regulatory frameworks, including appropriate competition laws. In the absence of appropriate competition legislation, foreign firms would drive out local competition and monopoly power would be used to drive up prices (Mashayekhi et al, 2002). However, domestic competition policies are notoriously ineffective at dealing with global monopolies, who may or may not enjoy a monopoly in the domestic market. This is an area that needs serious attention, especially if the effect of GATS is to displace local service suppliers with international ones who are frequently monopolies or cartels themselves.

Political issues

There is a need to **safeguard policy space** in order to meet national policy objectives – operationalisation of GATS Article XIX. Social and developmental concerns should be fully and effectively integrated into trade policies. However, experiences with environmental protection have shown that the WTO is the inappropriate forum for this as it is preoccupied with purely trade issues. Governments can, however, incorporate social and development concerns directly into their schedules and should not be hesitant to include direct references to international conventions so that they are taken into account when disputes arise.

Reciprocity is the basis for international trade negotiators. Frequently African countries do not benefit from concessions. Countries in our region need to claim the available opportunities for the protection of public health. Concessions granted under GATS by developed countries do not materialise into actual export gains, and are therefore in most part non-reciprocal.

Areas of follow up work

There is a need to conduct a comprehensive review of the regulations and practices of southern African states so that the regulatory environment and impact of health reforms can be better under GATS induced changes. Since GATS' main focus is on regulation, detailed analysis needs to be conducted on countries' GATS compliance with their current commitments and in the extreme scenario of full commitments being made. The latter is necessary since an extreme position will highlight the key areas of regulatory focus that will need to be excluded from GATS coverage in future commitments.

Another area of research, on which scant information is available, is that of the linkages between the health sector and other services sectors and their impact. The EU bananas case points to severe limitations in policy flexibility for developing countries especially and this needs to be investigated thoroughly (Raghavan, 2002). Until an assessment of the linkages between the various essential and non-essential sectors has been concluded it would be unwise to enter into any commitments – not just in health but also in transport, wholesale and retail distribution and so on. Investigations also need to be conducted on how developing countries can incorporate their particular concerns regarding domestic regulation into the schedule of commitments, so that they do not have to rely on bargaining power to have them included.

Research needs to be conducted into the broader contextual environment in which health operates and into the specific areas of regulation. The draft working paper, 'Trade in Health Related Services and GATS: General Framework for Country Analysis'[19] provides a questionnaire of the essential data required when analysing the impact of GATS or contemplating further commitments in the sector.

The complexity of GATS requires public institutions to develop their technical capacity. Trade negotiators, regulators and CSO stakeholders need to improve their co-operation to ensure that GATS does not undermine pro-equity goals. In this vein, EQUINET and SEATINI are embarking on a process to develop skills and a knowledge base of GATS' relevant concerns. This knowledge base is to be developed by CSO and government officials co-operating and pooling research resources. EQUINET and SEATINI can provide mentoring services to public institutions to ensure that public institutions are able to maximise their use of policy flexibility that is currently available in GATS. Similar challenges are faced by northern and other southern countries and efforts are underway to promote south-south and north-south cooperation.

The systemic challenges facing developing countries are larger issues, which need to be publicised and dealt with at all international fora where these issues are discussed and the inherent unfairness in the system exposed.

[19] Chanda et al (2003) unpublished but presents a workable insight into the systemic and specific challenges the GATS poses.

Table 2: Summary of specific commitments as at 1 January 1995, all sectors for southern African countries (excluding Seychelles)

Country	Business services	Communication services	Construction & related engineering services	Distribution services	Educational services	Environmental services	Financial services	Health and related social services	Tourism and travel related services	Transport services	Recreational cultural & sporting services	Other services not included elsewhere
1. Angola							X		X		X	
2. Botswana	X	X							X			
3. D. R. Congo	X	X	X		X				X		X	
4. Lesotho	X	X	X	X	X	X	X		X	X		X
5. Malawi	X		X					X	X			
6. Mauritius		X							X			
7. Mozambique							X					
8. Namibia	X								X			
9. South Africa	X	X	X	X		X	X	X	X	X		X
10. Swaziland	X							X	X			
11. Tanzania									X			
12. Zambia	X		X					X	X			
13. Zimbabwe		X					X		X			

Table 3: Schedule of commitments for some SADC countries

Botswana: Schedule of specific commitments

All modes of supply.

Sector or sub-sector	Limitations on market access	Limitations on national treatment
1. Horizontal commitments Botswana		
All sectors included in this schedule	1), 2) None	1), 2) Capital remittances and transfer of funds require approval of the Bank of Botswana (Central Bank). Fees payable the Bank of Botswana (Central Bank). Fees payable to non-resident service supplier are subject to approval of the Bank of Botswana.
	3) All juridical persons must be registered with the Registrar of Companies. All juridical persons are required to have a licence issued by the relevant authorities.	3) The Government does not have a fixed ratio of equity between foreign and local companies. But foreign investors are encouraged to enter into joint ventures with local investors. Juridical persons who specialise in providing services should be registered in their countries of origin. The Ministry of Commerce and Industry should be notified of all sale of business interests, mergers and take-overs. When foreign investors sell their interests in resident companies, locals should be given priority to purchase such interests.
	4) Entry and residence in Botswana of foreign natural persons is subject to immigration laws, regulations, guidelines and procedures. Employment in Botswana of foreign natural persons is subject to labour laws, regulations and procedures. For a foreign natural persons to work in Botswana a residence and work permit is required. Foreign naturals shall be employed bycompanies that provide services withinBotswana only as managers, executives,special technicians and highly qualifiedprofessionals. Investors are required to conform to the requirements of the localisation policy. Investors are required to train citizens in order to enable them to assume senior management positions over time. Professionals are required to register with the appropriate professional body.	4) Professional foreign natural persons should be recognised as such and they should have rights to practise in their countries of origin. Professional foreign natural persons should be recognised and be registered by the appropriate committee or council.

Lesotho: Schedule of specific commitments

All modes of supply.

Sector or sub-sector	Limitations on market access	Limitations on national treatment
1. Horizontal commitments Lesotho		
All sectors included in this schedule	1) None	1) None
	2) None	2) None
	3) Foreign-owned enterprises including joint-venture enterprises with Lesotho, must satisfy minimum capital outlay and foreign equity requirements as follows: Wholly foreign-owned company requires a minimum equity capital outlay of US$200,000. Joint-venture company should have a minimum foreign-equity capital outlay of US$50,000 in cash or in kind. Agency establishment must have authority to negotiate and conclude contracts on behalf of foreign parent company.	3) None
	4) Automatic entry and work permit is granted for up to 4 expatriate senior executives and specialised skill personnel in accordance with relevant provisions in the Laws of Lesotho. Approval is required for any additional expatriate workers beyond the automatic level. Enterprises must also provide for training in higher skills for the locals to enable them to assume specialised roles.	4) None

Malawi: Schedule of specific commitments

All modes of supply.

Sector or sub-sector	Limitations on market access	Limitations on national treatment
1. Horizontal commitments Malawi		
All sectors included in this schedule		3) With permission from the Reserve Bank of Malawi, a foreign-controlled company can obtain loans or overdrafts of up to one third of the value of its paid up capital.
	4) Unbound except for measures concerning the entry and temporary stay of natural persons employed in management and expert jobs for the implementation of foreign investment. The employment of such persons shall be agreed upon by the contracting parties and approved by the Ministry of Home Affairs.	4) Unbound except for measures concerning the categories of persons referred to in the market access column.

Mauritius: Schedule of specific commitments

All modes of supply.

Sector or sub-sector	Limitations on market access	Limitations on national treatment
1. Horizontal commitments Mauritius		
All sectors included in this schedule	3) To be governed by the provisions of: - Companies Act (1984) - Non-Citizens Property Restrictions Act (1975) - Non-Citizens Employment Restriction Act (1970) - Income Tax Act (1974) - Act No. 41 of Banking Act (1988) - Exchange Control Act.	3) Same as specified in the market access column.
	4) Unbound except for measures affecting the entry and temporary stay of highly qualified natural persons and will be governed inter alia by: - Passport Act, 1969 - Immigration Act, 1973.	4) Unbound except for measures concerning the categories of natural persons referred to in the market access column and will be governed inter alia by: - Income Tax Act - Non-Citizens Employment Restrictions Act, 1970

Namibia: Schedule of specific commitments

All modes of supply.

Sector or sub-sector	Limitations on market access	Limitations on national treatment
1. Horizontal commitments Namibia		
All sectors included in this schedule	3) Commercial presence requires that foreign service providers incorporate or establish the business locally in accordance with the provision of Namibian laws (Companies Act 61 of 1973). Enterprises with foreign investment in Namibia have the same rights and responsibilities as domestic enterprises.	
	4) The entry and residence of foreign natural persons (service providers) are subject to Namibia's Immigrations Control Act of 1993 and labour laws. In accordance with Namibian legislation, the employment of foreign natural persons for implementation of the foreign investment shall be agreed upon by the contracting parties and be subject to approval by the Namibian government, and such personnel shall be employed in management and expert jobs only.	

South Africa: Schedule of specific commitments

All modes of supply.

Sector or sub-sector	Limitations on market access	Limitations on national treatment
1. Horizontal commitments South Africa		
All sectors included in this schedule		3) Local borrowing by South African registered companies with a non-resident shareholding of 25% or more is limited.
	4) Unbound, except for measures concerning the categories of natural persons referred to in the market access column. **A. Services Salespersons -** natural persons not based in South Africa and acquiring no remuneration from a source located within South Africa, who are engaged in activities related to representing a services provider for the purpose of negotiating for the sale of the services of that provider, without engaging in making direct sales to the general public or supplying services. Temporary presence for Services Salespersons is limited to a 90-day period. **B. Intra-corporate Transferees -** natural persons of the following categories who have been employed by a juridical person that provides services within South Africa through a branch, subsidiary, or affiliate established in South Africa and who have been in the prior employ of the juridical person outside South Africa for a period of not less than one year immediately preceding the date of application for admission: **Executives -** natural persons within the organisation who primarily direct the management of the organisation or establish goals and policies for the organisation or a major component or function of the organisation, exercise wide latitude in decision-making, and receive only general supervision or direction from higher-level executives, the board of directors, or stockholders of the business. **Managers -** natural persons within an organisation who primarily direct the organisation, or a department or subdivision of the organisation, supervise and control the work of other supervisory, professional or managerial employees, have the authority to hire and fire or recommend hiring, firing, or other personnel actions and exercise discretionary authority over day-to-day operations at a senior level.	4) Unbound, except for the temporary presence for a period of up to three years, unless otherwise specified, without requiring compliance with an economic needs test, of the following categories of natural persons providing services.

South Africa: Schedule of specific commitments (cont)

All modes of supply.

Sector or sub-sector	Limitations on market access	Limitations on national treatment
1. Horizontal commitments South Africa		
All sectors included in this schedule	**Specialists** - natural persons within an organisation who possess knowledge at an advanced level of continued expertise and who possess proprietary knowledge of the organisation's product, service, research equipment, techniques, or management. **Professionals -** natural persons who are engaged, as part of a services contract negotiated by a juridical person of another Member in the activity at a professional level in a profession set out in Part II, provided such persons possess the necessary academic credentials and professional qualifications, which have been duly recognised, where appropriate, by the professional association in South Africa. **C. Personnel Engaged in Establishment -** natural persons who have been employed by a juridical person for a period of longer than one year immediately preceding the date of application for admission and who occupy a managerial or executive position and are entering South Africa for the purpose of establishing a commercial presence on behalf of the juridical person.	

Zambia: Schedule of specific commitments

All modes of supply.

Sector or sub-sector	Limitations on market access	Limitations on national treatment
1. Horizontal commitments Zambia		
All sectors included in this schedule		3) With permission from the Bank of Zambia, a foreign-controlled company can obtain loans or overdrafts of up to one third of the value of its paid up capital.
	4) Unbound except for measures concerning the entry and temporary stay of natural persons employed in management and expert jobs for the implementation of foreign investment. The employment of such persons shall be agreed upon by the contracting parties and approved by the Ministry of Home Affairs. Enterprises must also provide for training in higher skills for Zambians to enable them to assume specialised roles.	4) Unbound except for measures concerning the categories of persons referred to in the market access column.

Zimbabwe: Schedule of specific commitments

All modes of supply.

Sector or sub-sector	Limitations on market access	Limitations on national treatment
1. Horizontal commitments Zimbabwe		
All sectors included in this schedule	3) The following limitations apply to foreign investors who seek to acquire shares in companies listed on the Zimbabwe Stock Exchange. The purchase of shares is limited to 25% per counter of the listed issued share capital; this limit is in addition to any existing foreign holding in a company. A single investor is limited to a maximum of 5% of the shares on offer; foreign investors bringing in hard currency may invest a maximum of 15% of their assets in primary issues of bonds and stocks.	
	4) Unbound, except for measures concerning the entry and temporary stay of intra-corporate transfer of executive and senior managerial personnel and except for specialists, subject to lack of availability in the local labour market.	4) None, with respect to categories of natural persons referred to in the market access column. Unbound, with respect to measures concerning any other categories of natural persons.

Table 4: Summary of GATS obligations, opportunites and threats to public health

Gats main obligations	Description	Opportunity	Threat	Policy considerations
General obligations	These disciplines are applicable whether or not a member state makes specific commitments in a sector. Public services may be included if they do not fall within the narrow governmental exception.	Wherever possible secure most favoured nation exemptions or enter restrictive clauses in horizontal commitments.	Implementation of policies on services not covered by GATS increase these obligations. Countries that have not liberalised service sectors lose the incentive to liberalise as they already enjoy the benefit of market access; reciprocity needs to be ensured.	General obligations discipline a range of public service policy choices. Actors: Trade negotiators, public health officials and regulators.
Most favoured nation (MFN) treatment	Favour one, favour all. Favourable treatment to one country, regarding the import of a service, means that the same treatment must be given to all WTO members.	Limit application of this principle by adding horizontal limitations to any liberalisation.	The general application of Article II has equal standing with specific commitments and there does not appear to be a hierarchy of importance. A sector not scheduled gives rise to obligations if they are given to any foreign supplier.	Potential to undermine regional trade promotion. Actors: Regional trade negotiators – should monitor and track linkages between agreements.

Gats main obligations	Description	Opportunity	Threat	Policy considerations
Transparency	States must publish all relevant laws and regulations governing all service sectors.	What is meant by transparency should be dealt with at the multilateral level and not at the bilateral level.	This neutral clause in GATS has a disproportionate effect on developing countries. It will divert already scarce resources to administration rather than service delivery.	The need to provide resources for international transparency may be outweighed by other more pressing priorities. The key area of focus should not be more administrative tasks but better substantive services to users. Actors: Trade negotiators, public health providers (procurement & finance departments).
Economic integration	Regional Trade Agreements: countries come together and share a trading arrangement that: • allows discrimination • promotes intra regional trade.	By using service suppliers in the region, greater intra-regional trade may be promoted and complementarities between different economies can be built. Need to differentiate South-South from North-South regional integration arrangements.	GATS RTAs are no defence against foreign penetration of markets and may undermine the development of complementarities within a region.	Stronger and healthier neighbours will contribute positively to regional growth, risk and power sharing and interdependencies. Actors: Regional Trade Negotiators.
Domestic regulation	Disciplines that govern the: • process of review of administrative decisions; • authorisation for the supply of a service; • qualifications; • standards; • licensing; • recognition criteria (technical or otherwise) & should be based on *'objective and transparent criteria'* and should not be: • *'more burdensome than necessary';* and • 'unnecessary barriers to trade in services.'	Create flexible policy tools within GATS. Safeguard regulatory powers (necessity test, transparency disciplines, etc).	Standard of proof for regulations problematic as undefined. Does not address the critical question of regulating to guarantee access to and distribution of services. The marginalised that benefit from regulatory rents may no longer be protected.	Allocation of resources may be diverted from pursuing pro-equity goals. Regulations that promote equity may be subject to external decision-making bodies that undermine a member states ability to achieve its goals. Effect of GATS is displacement of local for foreign ownership in service suppliers. Differential regulation will encourage domestic companies to externalise their operations so that they may also benefit from the relaxed regulations.

Gats main obligations	Description	Opportunity	Threat	Policy considerations
Monopolies and exclusive service providers	Governments are obliged to ensure control over the behaviour of monopolies or exclusive service suppliers and are forbidden from creating new monopolies.	Retain the right to create monopolies and exclusive service providers. Monopolies and exclusive service providers are viable vehicles for utilising and implementing the principle of cross-subsidisation or for allocating resources in needy areas.	The use of cross-subsidisation is threatened. Lack of finances and monopoly structures may compromise revenue generation for universal access.	Market access commitments and horizontal commitments should retain the right to create monopolies to pursue legitimate public health equity goals.
Market access	Allows foreign companies to provide cross-border services in a country. Prohibits restrictions (based on economic needs tests) in the form of: • limits on the number of suppliers, operations or employees in a specific sector; • the value of transactions or assets; • the legal form of the supplier (for instance, limiting it to a branch or joint venture); and • the participation of foreign capital.	Words like 'economic needs tests' should be included in schedules to create policy flexibly. The commitment can then state in positive what type of market.	Market access commitments can affect resource allocation especially to less profitable areas. Market access commitments imply greater levels of scrutiny on domestic regulation. Domestic enterprises will face increased competition.	Control over market entry to promote health equity goals. Actors: Trade negotiators and Regulators – ensure adequate control over market access commitments.
National treatment	Foreign service suppliers in domestic market must be treated in the same way as domestic suppliers. • The treatment given to a foreign service supplier can be, 'formally identical or formally different.' • Different treatment required for foreign service supplier is at a competitive disadvantage to a domestic service supplier.	Domestic standards should be set for the relaxation of any regulations in favour of foreign suppliers to equalise the terrain of competition.	Subsidies to fund health services may have to be directed to foreign service suppliers resulting in the public subsidising private sector profits. Creates conditions for the displacement of local for foreign suppliers in the name of competition. Encourages externalisation of ownership of service suppliers to take advantage of relaxed regulations applicable to foreign service suppliers.	Control over domestic regulations to promote health equity goals. Actors: Trade negotiators and Regulators – ensure adequate control over the meaning and import of national treatment commitments.

Gats main obligations	Description	Opportunity	Threat	Policy considerations
National treatment exemptions	Government procurement (not for commercial purposes); necessary to: • protect public morals or maintain public order; • protect human, animal or plant life; and • maintain essential security interests.	To define the scope of the domestic regulation intrusion by GATS as narrow and to widen the space for sovereign regulation.	Interpretations by the DSB have provided very limited support for non-trade related societal goals or standards. Decision-making on exemptions is effectively externalised to the DSB.	Equity policy goals need to address deprivation and should be informed by domestically informed decision not external considerations. Actors: Trade negotiators and Regulators – ensure adequate powers to make public interest regulations.

Table 5: Reading a schedule

Schedule of commitment ←	**Horizontal commitments** → All modes and service sectors	
Specific commitments	National treatment	Market access
Sector/Classification:	In this schedule:	
Mode 1: Cross-border trade	**Unbound** means no commitments entered into, no GATS liberalisation.	**None** means no restrictions so there is full application of GATS, complete GATS liberalisation.

Table 6: Data and definitional challenges

	Description	Opportunity	Threat	Policy considerations & actors
Data and definitions	There is a paucity of data on trade in services.	To create mechanisms that meet the analytic demands of the health community to evaluate health policies.	No will to either assess or create useful methods of data collection. There will be limited empirical basis for evaluating the structural and policy changes.	Lack of data will hide the actual impact of GATS on health services with no hope of correcting data collection in the short to medium term. Actors: Statistical services and accountants within the member state must be enjoined to collect data.
National treatment	Formally identical or formally different treatment between local and foreign suppliers.	To limit the relaxation of domestic regulations irrespective of their impact on foreign service suppliers.	Different regulation for foreign and local service suppliers adds to the complexity of regulating the sector.	Sovereign rights over domestic regulation need to be maintained to pursue health equity goals. Actors: Trade negotiators must pursue flexible options and include suitable provisions in schedules.

	Description	Opportunity	Threat	Policy considerations & actors
	Relaxation of domestic regulations for foreigners is intended to compensate for advantages domestic suppliers may enjoy.		There is no real definition of what a level competitive terrain actually is and how much regulatory adjustment is required.	Empower domestic regulators to govern foreign service providers effectively. Actors: Legislators and public officials must ensure that regulators have the power to protect public health.
	Capacity of the regulator to deal with competitive terrain and actions of foreign private actors.	Review current regulations to gauge the appropriateness of: • regulatory authority to deal with foreign suppliers; and • relaxations of standards in favour of foreign suppliers.	Regulators are notoriously ineffective at dealing with global monopolies. Without appropriate competition legislation foreign firms can drive out local competition.	Actors: Competition regulators need to be sensitised and aware of the public health priorities. Regulators to ensure capacity and power and to deal with private actors under GATS.
	'None' entered in the schedule has different implications depending on the mode of supply.	Renegotiate, so that appropriate domestic regulations are not made illegal by GATS. Try to secure inclusion of a list of regulatory authorities and their powers to govern service sectors.	Legitimate regulations can be found to be illegal, inviting sanctions. A foreign supplier can raise any barrier to trade and request that it be relaxed.	GATS language is too wide and imprecise. Precision should be provided to restrict the application of GATS so that it does not compromise the sovereignty of a state. Actors: Trade negotiators.
Market access	Prohibits the application of economic needs tests and restrictions on the supply of services.	Use expansive language to create policy flexibility for domestic regulation and control over service supply. State commitments under market access in the positive instead of using GATS negatively stated articles.	Excluding economic needs tests will undermine the ability of members to introduce pro-equity policies by identifying the areas, persons or sectors that need help the most. The market is inappropriate to allocate resources efficiently and effectively and market access commitments increase reliance on market based allocations.	Profit in the provision of health services cannot be the key motivator for market access. Actors: Trade negotiators. Public health officials to identify health interests that can be compromised by market access and make recommendations.
	'None' entered in the schedule has different implications depending on the mode of supply.	Renegotiate, so that appropriate market access rules are not made illegal by GATS. Use domestic regulation authority to mitigate the lack of control over controlling market access.	No restrictions on the provision of a service can be applied even to pursue legitimate goals. The health sector could be segmented into profitable and non-profitable services leaving the non-profitable sectors to the overburdened public service.	Rights to domestic regulation must be explicitly claimed. Actors: Trade negotiators must seek reversals of these commitments. Regulators should claim regulatory space in the public interest.

	Description	Opportunity	Threat	Policy considerations & actors
National treatment exemptions	To exclude a service or regulatory measure from GATS it has to meet the standards of the necessity test.	Expansive language in making GATS commitments can expand the range of exemptions that a country could claim.	National Treatment & Domestic Regulation: National treatment as a legal concept in GATS agreement is very imprecise. Informing future behaviour of investors and regulators is risky and uncertain.	GATS language is too wide and imprecise. Precision should be provided to restrict the application of GATS so that it does not compromise the sovereignty of a state. GATS is intrusive and wide exemptions are needed to protect domestic flexibility. Actors: Trade negotiators
Domestic regulation	This disciplines demands that domestic regulation is: • objective and uses transparent criteria; • no more burdensome than necessary; and • not an unnecessary barriers to trade in services.	Safeguard regulatory powers of national policy makers by conveying precise and/or expansive meanings to terms in commitments. Domestic standards-setting bodies can be referred to, which can be encouraged to develop local standards that will govern regulation of liberalised GATS sectors.	Uncertainty and imprecision in the meaning of terms can result in: • reversals of policies that have been implemented if found illegal; • future behaviour becomes minimalist if there is no certainty; & • perfectly legitimate and valid regulations can be challenged.	Domestic regulation must be determined within a member state and not externally. Pro-equity considerations should not be undermined by GATS. Actors: Trade negotiators Regulators should explicitly state the powers they need to regulate effectively.
Govern-mental authority	Services that are supplied neither on a commercial basis, nor in competition with one or more service suppliers.	Ensure the general exclusion of public services from GATS either in horizontal limitations or in specific commitment schedules.	• Privatisation of public health services invokes GATS. • There is no exclusion of public services from GATS.	Actors: Trade Negotiators /Finance or Treasury departments – take care to ensure no inadvertent inclusion of service sectors under GATS.
Lock in of commit-ments	Members can only renegotiate their commitments and must pay compensation for changes they make.	Market access and national treatment should curb the 'lock in nature' of GATS liberalisation by including sector specific time limitations for domestic review of commitments under GATS. Specific standards could also be set for what constitutes a failure of a service (reduced access, inferior quality, high prices) to allow for governmental intervention.	Market access and domestic regulation implies that for new regulations they must have been contemplated at the time of entering the commitment. Circumstances change and regulations may have to be introduced that were not contemplated at the time of the agreement. Arguing that new regulations were foreseeable at the time commitments were made limits the scope for regulators to make policy.	Limits should not placed on the future of regulation of the sector; member states should retain this right.
	None: If full market access commitments are made no restrictions prohibited under market access and national treatment are allowable.		GATS is imprecise and the fuzziness of definitions will render the legality of future regulatory action uncertain.	Pro-equity regulations are threatened and need to be protected.

Table 7: Link between GATS and TRIPS

	Description	Opportunity	Threat
Links GATS & TRIPs	All the agreements of the WTO are linked to each other. Non-compliance under GATS can result in retaliation under goods trade.	Limit the cumulative nature of the obligations under the separate WTO agreements.	Sectors not directly regulated by GATS can be made to suffer for non-compliance with GATS rules. Actors: Public health officials within the ministry of health and those tasked with intellectual property regulation.
The threat of sanctions	Non-compliance with GATS can invite sanction in any area regulated by the WTO.	Violating TRIPS agreement can result in sanctions imposed in the area of services trade or goods trade.	Member states carry the burden of poorly defined cumulative rights and obligations.
Regulations on generic procurement	GATS may limit the policy flexibility through which government procurement is regulated.	Members can support the policy of prescribing generic rather than patent/brand names.	Foreign service suppliers create the potential for patent holders to challenge regulations promoting generics as illegal.
Government Procurement (Article VIII) & Governmental Exemption (Article I.3)			Mass procurement by the state cannot work without an effective distribution network. A public hospital dispensing cheaper drugs may be called upon to charge market related prices for the drugs to fee-paying clients and be constrained from using its procurement power to become more attractive to fee-paying clients.
Limitation of distribution networks	Distribution networks are also regulated by GATS. Interlinkages between service sectors are important.		If commitments are entered into in the transport, wholesale and retail distribution services sector a hospital's access to these products will also be governed by GATS because it is accessing a service from another sector that also shares GATS obligations.
Domestic production of pharma-ceuticals	Developing countries are allowed to compulsorily license a patented drug and produce it predominantly for domestic consumption. Any excess may be exported but production must be mainly for the local market (i.e. 51%).		State support is required to create and protect domestic producers of generic drugs.

Table 8: GATS systemic issues

	Description	Opportunity	Threat	Policy considerations & actors
Systemic issues	These general issues recognise the interdependency of health on other factors in the political economy.	To raise the complaints of institutionalised unfairness and inequity within the international trading system.	Continued participation in an unfair system will lead to further erosion of domestic policy space.	Fairness in international trade must be promoted. Reciprocity for concessions granted must be insisted upon.
Market regulation of health services	Health services provided on the basis of health as a commodity.	To monitor efficiency of private sector in detail.	Health is not seen as a basic service or human right.	The markets ability to deliver services and allocate resources effectively must be analysed with equity considerations.
Dispute settlement body	Substantive interpretations.	African countries can retain copies of the negotiating history to defend themselves in the DSB interpretations not intended at the time of making commitments, or for informing positions.	DSB will continue to make interpretations exceeding its mandate. Undefined terms in GATS will be challenged and given a substantive definition.	Efforts need to put into monitoring the progress of the Working Committee on Dispute Resolution and of the CTS.
	Sanctions.	Insist on a careful review of the DSB's decisions especially where it has exceeded its mandate and challenge adoptions where required.	If services are liberalised under GATS, the sanctions that can be imposed can be in any area of trade covered by the WTO.	Protect sovereign regulatory rights of member countries.
External control	Important decisions affecting African societies are not made by citizens or their representatives but by players outside the country.	Create conditions for co-ordinated interdepartmental and cross sectoral co-operation around trade in services challenges.	DSB decisions on interpreting GATS.	External prescriptions still drive many policy decisions. External influences should yield to domestic priorities.
Movement of natural persons	GATS allows for the movement of natural persons.	To set benchmarks for the entry of professional foreign personnel.	Allows for brain drain away from local market.	Increase equity by retaining skilled personnel.
Reciprocity	The principle of give and take.	Insistence on reciprocity and evaluation of market access as a starting point in negotiating further commitments.	Structural problems hinder Africans ability to export services.	Policy should focus on best meeting local demands and allocating resources to maximise domestic benefits.

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Equity in health *implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.*

EQUINET implements work in a number of areas identified as central to health equity in the region:

- Public health impacts of macroeconomic and trade policies
- Poverty, deprivation and health equity and household resources for health
- Health rights as a driving force for health equity
- Health financing and integration of deprivation into health resource allocation
- Public-private mix and subsidies in health systems
- Distribution and migration of health personnel
- Equity oriented health systems responses to HIV/AIDS and treatment access
- Governance and participation in health systems
- Monitoring health equity and supporting evidence led policy

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