



**THE GATS AND
SOUTH AFRICA'S
NATIONAL HEALTH
ACT**

A Cautionary Tale

Municipal Services Project

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**THE GATS AND
SOUTH AFRICA'S NATIONAL
HEALTH ACT**
A Cautionary Tale

By Scott Sinclair

Series Editors

David A. McDonald and Greg Ruiters

ABOUT THE PROJECT

The Municipal Services Project (MSP) is a multi-partner research, policy and educational initiative examining the restructuring of municipal services in South(ern) Africa. The Project's central research interests are the impacts of decentralisation, privatisation, cost recovery and community participation on the delivery of basic services to the rural and urban poor, and how these reforms impact on public, industrial and mental health.

The research has a participatory and capacity building focus in that it involves graduate students, labour groups, NGOs and community organizations in data gathering and analysis. The research also introduces critical methodologies such as 'public goods' assessments into more conventional cost-benefit analyses.

Research results are disseminated in the form of an occasional papers series, a project newsletter, academic articles/books, popular media, television documentaries and the internet.

Research partners are the International Labour Research and Information Group (Cape Town), Queen's University (Canada), Rhodes University (South Africa), the Human Sciences Research Council (Durban), EQUINET (Harare), the South African Municipal Workers Union, and the Canadian Union of Public Employees. The Project is funded by the International Development Research Centre (IDRC) of Canada.

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Preface

This Occasional Paper was first published electronically by the Canadian Centre for Policy Alternatives (CCPA) in December 2005. Following this electronic publication, the South African Municipal Workers' Union (Samwu) wrote to the South African Ministers of Health and of Trade and Industry, inviting them to comment on the paper. Samwu informed the Ministers that their response would be considered for inclusion in the hardcopy, as a postscript, with the additional possibility of responses from the primary author of the report, Scott Sinclair. Despite several reminders, no comments were received from either Ministry. The Minister of Trade and Industry did, however, acknowledge receipt of Samwu's letters.

The publication of this booklet is a unique collaboration between two research centres and two trade unions covering two continents. The Canadian Union of Public Employees (CUPE) has covered the costs of the research and the publication of this Occasional Paper. Samwu has been responsible for the launch of the booklet.

Roger Ronnie

Samwu General Secretary

May 2006

Acknowledgements

In August 2004 I received an e-mail from Jeff Rudin, the national research officer with the South African Municipal Workers Union (Samwu), introducing himself and asking for my advice on a perplexing matter. He was concerned about the potential inconsistency between South Africa's 1994 GATS commitments on health services and the country's new national health legislation.

I was well aware that this was a difficult and complex issue, having spent many hours with my colleagues at CCPA, particularly Matthew Sanger and Jim Grieshaber-Otto, analyzing the scope and meaning of Canada's own ill-advised GATS commitments covering health insurance and, more broadly, the impacts of trade treaties on the health sector. It was this published work that first brought the CCPA and me to Jeff's attention.

That initial contact grew, with the support and involvement of many others, into a productive collaboration and this paper. Roger Ronnie and John Mawbey at Samwu supported the project throughout. The Canadian Union of Public Employees, Samwu's sister union in Canada, played a key role. Without the enthusiastic support of Jane Stinson and Morna Ballantyne the project would never have been initiated. Stan Marshall and Sandra Sorensen saw it through to its conclusion. Karl Flecker and Tony Clarke, of the Polaris Institute, also deserve credit for flagging the issue during previous discussions with Jeff and other South African colleagues.

I was fortunate to have the opportunity to visit South Africa in February, 2005. Jeff and his colleagues at Samwu kindly hosted me in Cape Town. I benefited from a seminar at the Alternative Information and Development Centre and particularly from the trade policy expertise of Dot Keet. I wish to thank Riaz Tayob of the Southern and Eastern African Trade Information and Negotiations Institute (Seatini) for setting up a stimulating itinerary in Johannesburg which included sessions with anti-privatisation activists, an NGO policy roundtable, and a cordial dinner meeting with South African government trade officials and policy advisors on the GATS. While I benefited from all these interchanges with South Africans, the views expressed in the paper are my own.

Several South African and Canadian colleagues read and commented on parts or all of the draft. In particular, I wish to thank Chantal Blouin, Bruce Campbell, Sorraya Elloker, John Mawbey, David Sanders, Matthew Sanger, Gauri Sreenivasan, Riaz Tayob and Ken Traynor. Gary Schneider skillfully edited the draft. Tim Scarth and Kerri-Anne Finn formatted the paper for publication. I am grateful to David Sanders for graciously agreeing to contribute a foreword. As usual, I owe an immense debt to Jim Grieshaber-Otto who is a talented and treasured co-worker. He co-wrote the executive summary and commented on and improved several versions of the text. I wish to express my deep gratitude to Jeff Rudin, who skillfully guided the project from inception to completion, carefully read each draft, and suggested many improvements as the paper took shape. He has become a valued friend. Any remaining errors of fact or interpretation in the paper are my responsibility alone.

Finally, I wish to thank the many organizations that have provided financial assistance to the CCPA's Trade and Investment Research Project. Without their support this paper would not have been possible.

Foreword

It is a privilege to be able to write a foreword to this analysis of the implications for the health sector of South Africa's commitments under the General Agreement on Trade in Services (GATS), the publication of which is timed to coincide with the final phase of negotiations under the auspices of the World Trade Organisation (WTO). Scott Sinclair is to be congratulated not only for providing a clear exposition of the commitments to which the South African Government is (perhaps unwittingly) subscribed, but he is also to be thanked for alerting South African citizens to the dangers that this agreement poses to their constitutionally-guaranteed right to health and health care. The significance of this small publication lies not only in its obvious relevance to South Africa but also to the continuing struggle for health equity globally, for it exposes the breathtaking implications of one of the recently-devised and most far-reaching mechanisms for subjecting health care - as if it were any other commodity - to the unregulated forces of the market. Thus, it serves a very useful educational and advocacy function for policymakers, researchers and activists.

Sinclair shows how the outgoing apartheid regime, cynically or carelessly, sold South Africa's sovereignty and the right of its citizens to a more equitable health dispensation by signing up to the GATS. By laying bare the maze of bewildering legalese embedded in the articles of the GATS he shows how this trade treaty both threatens to further commercialize South Africa's already highly skewed health care system and also to undermine the redistributive thrust of the long-awaited National Health Act passed in 2004. Redressing apartheid's bitter legacy of stark inequities in health and access to health resources, that has been further aggravated by the ravages of an untimely HIV/AIDS epidemic, becomes even more daunting when it appears that appropriate policy responses are likely to be hamstrung by the restrictive GATS commitments detailed here.

In a thoughtful concluding section Sinclair suggests a set of possible responses to this urgent threat. The most compelling of these has parallels with South Africa's recent successful strategy in defeating the pharmaceutical industry and US Government's threatening campaign to overturn provisions in the Medicines Act of 1997 that were designed to lower the costs of drugs to treat AIDS. While other more cautious options are presented, it is convincingly argued that by exercising its moral right to withdraw its GATS commitments in health services South Africa would not only head off the threat posed by these to the right to health care of all its people, but such a response would also "send an important and salutary message that the GATS approach to health services is flawed and needs to be changed". This publication is mandatory reading for all those concerned with health and the moral imperative to provide health care to those millions for whom politics and history have denied this most basic of human rights.

David Sanders

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SUMMARY

South Africa's new flagship health legislation, designed to combat a daunting and urgent public health crisis, conflicts with legally binding commitments the former apartheid regime negotiated under the World Trade Organization's (WTO's) General Agreement on Trade in Services (GATS). This trade treaty conflict threatens to undermine the much-needed legislation and, if left unresolved, would make meeting the health needs of the majority of the population far more difficult. South Africa has several options for resolving this conflict in favour of its health policy imperatives, but each entails risk. South Africa's dilemma should serve as a world-wide warning that health policy-makers, governments and citizens need to be far more attentive to negotiations that are now underway in Geneva to expand the reach of the GATS.

South Africa's National Health Act (NHA) aims to remedy past injustices by creating a more uniform and egalitarian national health care system. It is the current government's chief legislative response to continuing health care challenges in a country where the social and economic costs of the worsening HIV-AIDS pandemic have greatly exacerbated the structural problems inherited from the apartheid era. Scarce health resources are still disproportionately directed to rich, urban, and white citizens.

South Africa's National Health Act (NHA) aims to remedy past injustices by creating a more uniform and egalitarian national health care system. The General Agreement on Trade in Services (GATS) is no ordinary trade treaty. It is exceptionally complex and broad in scope. It aims to expand international commerce by restricting government measures that impede the ability of foreign companies and investors to profit by supplying services, including health services. Once a national government agrees to cover a particular service sector under the GATS, this "specific commitment" binds all future governments, under threat of punitive trade sanctions. This is the difficult situation in which the current South African government finds itself with regard to its health legislation.

In 1994, South African negotiators made GATS commitments covering a huge swath of the country's health services.

South African trade officials have consistently denied that the country's health services are covered under the GATS. However, an examination of South Africa's GATS commitments, and the manner in which health services are classified under the GATS, reveals otherwise. A large swath of the country's health services - including almost all human health services delivered outside of hospitals by doctors, dentists, nurses, midwives and

other health professionals - are clearly covered by South Africa's 1994 GATS commitments.

The conflicts between South Africa's health legislation and the international services treaty are substantial. In general, public planning policies that allocate health resources more equitably between urban and rural areas, between rich and poor people, and between public and private sectors conflict with the GATS prohibitions against limiting the numbers or activities of private sector service providers.

The conflicts between South Africa's health legislation and the international services treaty are substantial.

In particular, the NHA's "certificate of need" system conflicts with the GATS Market Access rule (Article XVI). This system is the legislation's primary policy instrument, requiring all health establishments to acquire a "certificate of need" in order to operate. The legislation gives the health minister the authority to grant or refuse certificates based on community needs, and to set conditions on certificates, such as requiring health establishments to service poorly-served regions or populations, or to train community health care professionals. These basic measures, which are moderate and typical by world health policy standards, conflict with GATS Article XVI:2. This GATS provision explicitly prohibits the application of such "economic needs tests" to the approval of new facilities or the expansion of existing health establishments.

The GATS also threatens the health legislation and related policies in other ways. The application of the GATS National Treatment rules (Article XVII) to all health sectors and sub-sectors listed in the South African schedule of commitments creates a host of regulatory issues and problems. Community-based control and decision-making, local training and technology transfer options, directed health care subsidies and incentives, and black economic empowerment policies are all at risk.

GATS negotiations are currently underway on Domestic Regulation (GATS Article VI:4). If these negotiations result, as planned, in new restrictions on non-discriminatory government regulation, the apartheid-era commitments covering health services would create further problematic conflicts with the National Health Act.

The approaches embodied in South Africa's current health policies and its GATS commitments are incompatible. The government can choose either to conform to legally binding, but illegitimate, treaty commitments made by apartheid-era negotiators, or it can implement the NHA and related policies to try to achieve a more equitable health care system. The existing inequities within the health care system are in need of urgent reform. There is also an overarching responsibility, enshrined in South Africa's constitution, for the state to protect health and other basic human rights. Accordingly, the morally and constitutionally valid way for the government to resolve these conflicts is to bring the country's GATS commitments into conformity with South Africa's health policy imperatives.

The approaches embodied in South Africa's current health policies and its GATS commitments are incompatible.

Failure to resolve this trade treaty issue promptly could, over time, divert effort and scarce resources from the central task of health care reform. It would enable foreign for-profit health service corporations, through their home governments, to launch GATS challenges that could thwart the implementation of the National Health Act and related policies.

There are several possible options for dealing with the GATS problem.

One option is for South Africa to implement the National Health Act as planned, and deal with any potential GATS issues as they arise. This "wait-and-see" approach is, however, unlikely to be effective over time. Due to the stark inconsistency between the NHA and the GATS, disputes are to be expected. Losing such a case would expose South Africa to the threat of trade sanctions targeted against the country's key exports.

Another option is for South Africa to withdraw its GATS commitments covering health services. This approach would resolve the immediate GATS threat to the NHA. A drawback, however, is that South Africa would be required to negotiate increased GATS coverage in other sectors to compensate affected WTO member governments for their service suppliers' lost "market access" in health services.

A third, more ambitious approach would begin with the withdrawal of the GATS commitments. This would be accompanied by the South African government leading or participating in collective action by like-minded governments and citizen movements to tackle the threats that the GATS poses to progressive health policies. The GATS and similar treaties must be fundamentally changed to address the basic incompatibility between their commercializing imperatives and policies to realise health as a human right for all.

The GATS is corrosive to a variety of public service systems and to regulation in the public interest. Instead of the current negotiations to broaden and deepen GATS coverage, there needs to be a thorough assessment of the treaty's defects from a health policy and public interest perspective, and joint international action for concrete changes to remedy its structural flaws.

Bringing South Africa's GATS obligations into line with its new national health legislation should be viewed as a necessary first step towards the vital goal of creating more democratic international governance frameworks for human and social development.

Instead of the current negotiations to broaden and deepen GATS coverage, there needs to be an assessment of the treaty's defects and joint international action to create more democratic international governance frameworks.

INTRODUCTION

In July 2004, South Africa passed its long-awaited National Health Act. This legislation, enacted after nearly a decade of debate, is designed to rectify severe health inequities resulting from apartheid and to combat mounting public health crises, including the HIV-AIDS pandemic.

Ten years earlier, negotiators in Geneva were concluding the Uruguay Round trade negotiations that would transform the General Agreement on Trade and Tariffs (GATT) into the World Trade Organization (WTO).

These two events – a health policy initiative in a developing country making the transition from a racist regime to a multi-racial democracy and an international trade treaty concluded in the corridors of Geneva – might appear to be far-removed and unrelated. Regrettably, in the era of globalization, they are not.

Unlike its GATT predecessor, the new WTO is about far more than reducing tariffs and other border restrictions on trade in goods. Its agreements restrict member governments' role in regulating global commerce, affecting diverse matters such as intellectual property, standards-setting, and trade and investment in services.¹ These rules are enforced through a binding dispute settlement system, backed up by trade sanctions.²

One of these new WTO agreements, the General Agreement on Trade in Services (GATS) has been described as "perhaps the most important single development in the multilateral system since the GATT itself came into effect in 1948."³ The GATS restricts government measures affecting international commerce in services, including health services. By doing so, it risks interfering with the ability of countries to democratically develop their own health-care systems.

When the GATS was negotiated and ratified, there was little debate in South Africa or elsewhere about its possible negative impacts on health policy. Yet careful examination of the relationship between South Africa's new national health legislation and the GATS confirms that these threats are real. As the risks become more apparent, health policy-makers and the public are beginning to recognise their significance, even though trade officials and corporate lobbyists vigorously downplay these threats.

Exploring the relationship between the GATS and the National Health Act (NHA) also sheds new light on one of the great controversies of globalisation: the impacts that complex and far-reaching commercial treaties have on the democratic authority of governments to realise the

human rights of their citizens, particularly the poor and marginalised.

This is a cautionary tale. It is the story of an illegitimate regime tying the hands of future democratic governments. Trade officials working under the apartheid regime negotiated binding GATS health services commitments that clearly conflict with crucial aspects of the new South African government's flagship health legislation.⁴ While legal from a trade law perspective, the commitments are unethical and illegitimate from the standpoint of human rights and democratic self-determination.

Trade officials working under the apartheid regime negotiated binding GATS health services commitments that clearly conflict with crucial aspects of the new South African government's flagship health legislation.

It is an account of a treaty that is cloaked in complexity and secrecy. Health policy-makers and the general public were left in the dark about potential negative impacts on national health policy. There was little communication about the potential risks associated with the GATS commitments. More than a decade after the GATS came into effect, South African trade officials continued to insist that the country did not have any commitments covering health.⁵

South Africa's National Health Act dilemma provides concrete evidence of the adverse consequences of GATS commitments covering health services. It demonstrates how the treaty privileges commercial interests and the minority that can afford to access private health services in the global marketplace over public policies aimed at achieving access and equity for the majority of the population.

It also highlights the dangers of trade policy overreach. Binding international rules now intrude into and undermine matters that are only secondarily related to trade, matters that ought to be determined and continually refined through democratic processes.

While it is possible for the current South African government to extricate itself from these ill-advised commitments, this process will not be easy and will require South Africa to compensate other WTO governments for their companies' lost market access.

Finally, like all cautionary tales, there is a universal lesson. Health-policy makers, governments at all levels, social movements, and citizens around the world must be far more attentive to current international commercial treaty-making. This also suggests the need for fundamental change to, and a scaling-back of, these complex and ambitious treaties to ensure that democratic health policy initiatives can proceed without trade law interference.

BASIC ARCHITECTURE OF THE GATS

The GATS is no ordinary trade treaty. It aims to expand international commerce, but it does so entirely by restricting or prohibiting government measures that interfere with the ability of foreign companies and investors to profit by supplying services, including health services. The GATS' commercialising impetus differs from the ethos of much public health policy and regulation, which is often deliberately designed to limit commercialisation in the interests of universal care and access.

GATS scope and coverage

The scope of the treaty is extremely broad. It applies to all government measures affecting trade in services. No service sector is excluded "a priori." The treaty covers measures taken by all levels of government - central, regional and local.

The GATS defines "trade in services" quite unconventionally to include not just cross-border trade - where a supplier located in one country provides a service to a consumer located in another - but also any other way in which companies or individuals can supply services internationally.

The four GATS "modes of supply" are:

- Cross-border services trade (mode 1) is the mode closest to the conventional meaning of international trade. It includes, for example, a radiologist located in a foreign country analysing an x-ray or scan and providing a diagnosis for a patient located in South Africa.
- Consumption abroad (mode 2) includes "medical tourism," where a foreigner travels to South Africa to undergo surgery.
- Commercial presence (mode 3) includes all forms of foreign direct investment; such as a European health care corporation establishing or investing in a South African hospital or clinic.
- Movement of natural persons (mode 4) is the mode which covers persons travelling internationally to provide services; for example, when South African health professionals go abroad temporarily to work in other countries.

Obviously, the GATS covers an extraordinary range of health service activities. It restricts (at least in principle) almost any government measure

that has an effect on such services. In the health sector, where public provision and government regulation play such a central and essential role, this broad coverage is raising concern with policy-makers and the public.

The limits of GATS flexibility

The strongest provisions of the GATS are conditional, applying only to those sectors that governments specifically agree to cover.⁶ This coverage is spelled out in each country's "schedule," a special annex that lists the sectors or sub-sectors that each country has agreed to cover, along with any conditions that the government places on these commitments. Country schedules are an integral and legally binding part of the GATS.

In theory, each member government has the ability to list only those sectors or sub-sectors it wishes, to choose which modes of trade it wants to cover in its GATS schedule, and to put conditions (referred to as limitations) on the commitments it makes. This latitude in scheduling is the main source of what is often referred to as the flexibility of the GATS.

In practice, the vaunted flexibility of the GATS is less than it first appears. The GATS is part of the WTO "single undertaking", meaning that governments had no choice but to be part of the GATS if they are WTO members. Governments also face strong negotiating pressure to make further substantial GATS commitments. Indeed, the treaty mandates successive rounds of negotiations to broaden and deepen GATS coverage.

In any case, GATS flexibility evaporates once specific commitments are made. Governments have just one opportunity, at the time they make the original commitment, to schedule limitations that protect policy measures in covered sectors. In trade jargon, governments must "list or lose" any non-conforming measures in these committed sectors. Moreover, once any national government makes a GATS commitment, it binds all future governments (national, state and local) whose future policies must then be GATS-consistent.

This is the predicament in which the current South African government finds itself today with regard to health services. The specific commitments covering health services negotiated under the apartheid regime interfere with the ability of the new government to address current health policy priorities.

SOUTH AFRICA'S GATS COMMITMENTS COVERING HEALTH SERVICES

South Africa's GATS schedule includes specific commitments covering certain health services. These commitments cover a wide range of essential health services and apply across a variety of modes of supply. The South African government made commitments covering medical and dental services, as well as services provided by midwives, nurses, physiotherapists and paramedical personnel.

Table 1: With regard to health services, the relevant part of South Africa's schedule⁷ reads:

Sector or sub-sector	Limitations on market access	Limitations on national treatment
1. Business Services A. Professional Services		
h. Medical & dental services (CPC 9312)	1) None 2) None 3) None 4) Unbound except as indicated in the horizontal section	1) None 2) None 3) None 4) Unbound except as indicated in the horizontal section
j. Services provided by:		
(i) midwives and nurses (CPC 93191)	1) Unbound* 2) None 3) None 4) Unbound except as indicated in the horizontal section	1) Unbound* 2) None 3) None 4) Unbound except as indicated in the horizontal section
(ii) physiotherapists and paramedical personnel	1) Unbound* 2) Unbound* 3) None 4) Unbound except as indicated in the horizontal section	1) Unbound* 2) Unbound* 3) None 4) Unbound except as indicated in the horizontal section

*Unbound due to lack of technical feasibility.

How to read the GATS schedule

For each covered sub-sector, the above schedule indicates the GATS commitments the government undertakes regarding market access and national treatment for each of the four modes of supply. This results in eight entries per sector.

GATS scheduling terminology is counterintuitive and needs explanation. When a government inscribes “None” in its schedule, it means there are no sector-specific exceptions or conditions (also known as “limitations”) for the specified mode of supply. Thus “none” actually refers to no limitations, and denotes full coverage (with no exceptions) in the specified sector. When a government inscribes “Unbound” in its schedule, it makes no commitments to cover that sector and is free to maintain or introduce measures that would violate the GATS market access and national treatment rules.⁸

South Africa’s schedule of health services commitments reveals that the government made full commitments to open “medical and dental services” (CPC 9312) for mode 1 (cross-border trade), mode 2 (consumption abroad) and mode 3 (commercial presence). It did not inscribe any market access or national treatment limitations to protect its health policy flexibility in these sectors. In the cases of nurses, midwives, physiotherapists and paramedical personnel (CPC 93191), South Africa has not made any commitments in mode 1 (cross-border trade). This mode of supply is marked “unbound,” because, in the government’s judgement, it is not “technically feasible” to supply these services on a cross-border basis. South Africa has, however, made full commitments to open all of these service sectors in mode 3 (commercial presence). Regarding nurses and midwives, it has also made full commitments in mode 2 (consumption abroad), while for physiotherapists and paramedical personnel, it has made no mode 2 commitments because the government asserts that it is not technically feasible to supply such services through consumption abroad.⁹ Again, despite the central role that nurses and midwives play in the South African health system, here are no limitations to protect the government’s health policy flexibility in the covered modes and sectors.¹⁰

Regarding mode 4 (the movement of natural persons), South Africa has no commitments, “except as indicated in the horizontal section.” This horizontal section is found at the beginning of South Africa’s schedule.¹¹ The commitments described there provide, among other things, for the temporary cross-border movement of health professionals “who are engaged, as part of a services contract negotiated by a juridical person [i.e. a corporation] of another member, 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.”¹²

The meaning and policy impact of these GATS commitments will be discussed in Sections 3 and 5 of this paper. First, it is necessary to discuss the precise scope of the covered health sectors and sub-sectors.

How health services are classified under the GATS

As recently as June 2005, a senior South African trade negotiator insisted that South Africa has made no GATS commitments covering health services.¹³ Examining South Africa's GATS schedule, however, clearly reveals otherwise. The distorted, and misleading, rationale for trade officials' claim that the country's schedule does not cover health services hinges on the peculiar way that health services were classified by trade negotiators during the Uruguay Round talks.

South Africa's GATS schedule includes specific commitments covering a wide range of essential health services.

In international commercial treaties such as the GATS, negotiators must agree to use a common classification system that defines the scope of the commitments made. Classification is not merely a technical matter; it is vital to interpreting the extent of legally enforceable commitments and to settling any future disputes.¹⁴

South Africa, like most other WTO member governments, followed the classification system set out in two documents -- the Services Sectoral Classification List (or W-120)¹⁵ prepared by the GATT secretariat during the Uruguay Round negotiations, and the United Nations' Provisional Central Product Classification (or provisional CPC). The W-120 is a rudimentary classification system, and to provide more detail and legal certainty, it is cross-referenced to the provisional CPC.

As explained on the WTO web site, the W-120 classifies hospital, residential health facilities, and ambulance services under Section 8, "Health-related and social services."

"The sector includes hospital services, services delivered under the direction of medical doctors chiefly to in-patients aimed at curing, reactivating and/or maintaining the health status; other human health services, ambulance services, residential health facilities services other than hospital services; social services with or without accommodation. The definition of health-related and social services does not include medical and dental services, veterinary services and the services provided by nurses, midwives etc., which have been grouped separately under professional services."¹⁶

As this description notes, however, a range of other health services are classified separately, under Section 1, Business Professional Services. South Africa has made nearly full commitments to cover those professional health services listed under Section 1 (Section 1: A, h-j; see *Box 1* below).

Box 1: the W-120 classification of “professional services”**1. Business Services**

- A. Professional services
 - h) Medical and dental services
 - i) Veterinary services
 - j) Services provided by midwives, nurses, physiotherapist and paramedical personnel.

No detailed description of these covered health services occurs either in the South African schedule or the W-120. The numbered CPC references in South Africa’s schedule, however, refer explicitly to the services sections of the provisional CPC, which does provide a more detailed description. Therefore, to determine precisely which health services are covered by South Africa’s GATS commitments, it is necessary to examine the CPC’s more detailed descriptions of the covered sectors and sub-sectors.

The provisional CPC descriptions of South Africa’s covered health services

The provisional CPC is a classification system for goods and services developed under the auspices of the United Nations. While the provisional CPC was produced primarily for statistical purposes, it was used by most WTO member governments as the basis for classifying their GATS commitments.¹⁷ The system “is exhaustive (all goods and services are covered) and its categories are mutually exclusive (a given good or service may only be classified in one CPC category.)”¹⁸

To understand the scope of the health commitments in South Africa’s schedule, it is necessary to understand how these services are classified and described under the CPC. The services sections of the provisional CPC are hierarchical and divided into Sections, Divisions, Groups, Classes and Sub-classes.

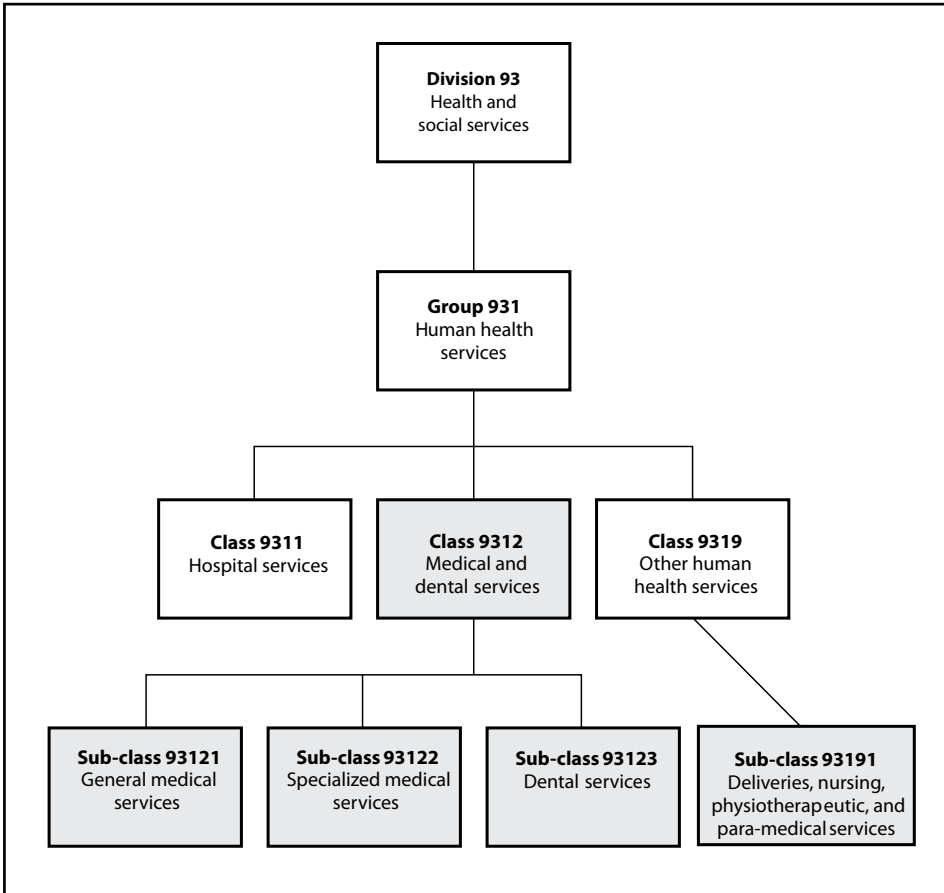
Unlike the W-120, the provisional CPC groups professional and institutional health services together. Human health services are classified in Group 931, which falls under Division 93 “Health and Social Services” in Section 9 “Community Social and Personal Services.” (see Box 2 on page xx

Scope of South Africa’s health services commitments

To summarise these detailed commitments: almost all human health services administered or supervised outside of hospitals by doctors, dentists, nurses, midwives and other health professionals (such as psychiatrists) are covered by South Africa’s GATS commitments. Even certain specialised health services delivered in hospitals (through out-patient clinics or day surgery) are covered if they do not do not involve an

overnight stay.¹⁹ By any reasonable estimation, this is a huge swath of the country's health services.

Box 2: Health Services Covered by South Africa's GATS commitments (by CPC categories, shaded boxes denote covered services)



Almost all human health services administered or supervised outside of hospitals by doctors, dentists, nurses, midwives and other health professionals are covered by South Africa's GATS commitments.

The South African apartheid government negotiated these extensive GATS commitments covering health services with little or no public debate. Many years later, when confronted with these commitments, South African trade officials initially denied that the country had made any GATS commitments covering health services. Subsequently, certain officials acknowledged these commitments, but remained tight-lipped about their policy impacts.²⁰

Whether deliberate or the result of confusion, this obfuscation is unacceptable. From a public policy standpoint, it is irrelevant whether the covered sectors fall

under the heading “professional services” (as in the W-120) or under the heading “health and social services” (as in the provisional CPC). What matters is that human health services have been covered and that government measures affecting these covered services are now restricted by the GATS.

It is high time for South Africans to have the public and political debate that should have occurred before these health services commitments were ever made. It is to the impact of these GATS commitments on South Africa’s health regulatory autonomy in general, and on the National Health Act in particular, that this paper now turns.

Box 3: Detailed Description of Human Health Services Covered In South Africa Schedule

General medical services (Sub-class 93121)

“Services consisting in the prevention, diagnosis and treatment by doctors of medicine of physical and/or mental diseases of a general nature, such as consultations, injections (limited and/or periodical), physical check-ups, etc. These services are not limited to specified or particular conditions, diseases or anatomical regions. They can be provided in general practitioners’ practices, and also delivered by out-patient clinics, attached to firms, schools, etc.”

Specialised medical services (Sub-class 93122)

“Diagnosis and treatment services by doctors of medicine of diseases of a specific nature, delivered in a specialists’ practice or health institution (including hospital in-/out-patient clinics).

These services are defined as those limited to specific or particular conditions, diseases or anatomical regions (except dental services), such as medical services for the following: nervous system; eye; ear, nose and throat; respiratory system; circulatory system; digestive system; hepatobiliary system and pancreas; musculoskeletal system connected tissues; skin, subcutaneous tissue and breast; endocrine, nutritional and metabolic diseases and disorders; kidney and urinary tract; male reproductive system; female reproductive system; pregnancy, childbirth and puerperium; newborns and other neonates; blood and bloodforming organs; myeloproliferative disorders; infectious and parasitic diseases; mental diseases and disorders; substance use and substance induced organic mental disorders; injuries, poisonings and toxic effects of drugs; burns; factors influencing health status and other contacts with health services (e.g. rehabilitation, aftercare, etc.).

Exclusion: “Services of medical laboratories are classified in subclass 93199 (Other human health services).²¹

Dental services (Sub-class 93123)

“Diagnosis and treatment services of diseases affecting the patient’s teeth or aberrations in the cavity of the mouth, and services aimed at the prevention of development of dental diseases, including dental surgery even when given in hospitals to in-patients. These dental services can be delivered in health clinics, such as those attached to schools, firms, homes for the aged, etc., as well as in own consulting and operating rooms. It concerns services in the field of general dentistry, such as routine dental examinations, preventive dental care, treatment of caries, etc.; orthodontic services, e.g. treatment of protruding teeth, crossbite, overbite, etc.; services in the field of oral surgery; other specialized dental services, e.g. in the field of periodontics, paedodontics, endodontics and reconstruction.”

Deliveries and related services, nursing services, physiotherapeutic and para-medical services (Sub-class 93191)

“Services such as supervision during pregnancy and childbirth and the supervision of the mother after birth. Services in the field of nursing (without admission) care, advice and prevention for patients at home, the provision of maternity care, children’s hygienics, etc. Physiotherapy and para-medical services are services in the field of physiotherapy, ergotherapy, occupational therapy, speech therapy, homeopathy, acupuncture, nutrition instructions, etc.

Source: UN Central Product Classification System, available at United Nations Statistics Division, <http://unstats.un.org/unsd/cr/registry/regcst.asp?Cl=9&Lg=1>.

SOUTH AFRICA'S NATIONAL HEALTH ACT (2004)

The constitutional right to health

- The constitutional protection of the right to health has been justly celebrated as a cornerstone of the new South African democracy. The South African constitution enshrines access to health services as a human right in several ways:
- section 27(2) of the Constitution requires that the State must take reasonable legislative and other measures within its available resources to achieve the progressive realisation of the right of the people of South Africa to have access to health care services, including reproductive health care;
- section 27(3) of the Constitution provides that no one may be refused emergency medical treatment;
- section 28(l)(c) of the Constitution provides that every child has the right to basic health care services;
- section 24(a) of the Constitution provides that everyone has the right to an environment that is not harmful to their health or well-being and;
- section 10 of the Constitution guarantees everyone the right to have their inherent dignity respected and protected.

By entrenching these rights, the framers of the constitution acknowledged the morally and legally binding responsibility of South African governments to ensure that the entire population has access to adequate health care.

Health policy challenges

The challenges that South African governments and society face in giving effect to this right are daunting. A 1997 white paper on health prepared by the newly-elected African National Congress government portrayed the serious inequalities and inefficiencies of the health care system inherited from the apartheid regime:

“In 1992-93, South Africa spent approximately 8.5% of GDP on health services, both public and private. This represents a very high level of spending for a country at South Africa’s level of development. However, the distribution of resources is highly inequitable and wasteful. A small proportion of the population benefits disproportionately from services rendered by the private sector, which are comparable to those offered in more affluent countries. At the same time, the majority of the South African population has very limited access to any form of services.”²²

Today, apartheid’s noxious racial segregation of hospitals and clinics has been dismantled. Yet, despite renewed public investment, severe inequalities based on race, gender and economic status persist. A July 2005 official document sounds much like the earlier white paper as it describes a public-private system that misallocates scarce health resources:

“There is a small minority of South Africans, (between 15 and 20 percent of the population) who have a high degree of access to health services and a large majority (between 75 and 80 percent of the population) who have limited access to health services. According to the latest figures, the state spends some R33.2 billion on health care for 38 million people while the private sector spends some R43 billion servicing 7 million people.”²³

Throughout the 1990s, the social and economic costs of the worsening HIV-AIDS pandemic have greatly exacerbated the structural problems inherited from the apartheid era. UNAIDS estimates that at the end of 2003 there were 5.3 million people in South Africa living with HIV - 21.5% of the population. This pandemic affects all parts of the population,²⁴ though women are more likely to be infected than men. An estimated 370,000 South Africans had died of AIDS-related causes by the end of 2003.²⁵

The scourge of HIV-AIDS burdens the health care system by increasing demands for treatment, decimating the ranks of front-line health care workers, and worsening poverty and inequality. At the same time, the shortcomings and inequality in the current system hamper effective treatment. Lack of health infrastructure, particularly in rural areas, and difficulties in accessing medical services faced by vulnerable groups such as pregnant women, frustrate plans to control the spread of the disease and to provide treatment to those living with HIV-AIDS. Ironically, another WTO treaty, the Trade-related Intellectual Property Rights Agreement (or TRIPS), is also a major obstacle to treatment. It enforces excessive monopoly patent protection for desperately needed anti-retroviral drugs.²⁷

The HIV-AIDS pandemic makes achieving the goals of the National Health Act both more difficult and more urgent. In fact, the goals of the Act and the comprehensive plan for care and treatment of people living

with HIV-AIDS, adopted in 2003, are complementary and interdependent. The treatment plan promises that within a year there will be “at least one [antiretroviral] service point in every health district across the country, and within five years, one service point in every local municipality.” It also involves “upgrading our national healthcare system . . . recruitment of thousands of professionals and a very large training programme to ensure nurses, doctors, laboratory technicians, counsellors and other health workers have the knowledge and the skills to ensure safe, ethical and effective use of medicines.”²⁸

Achieving a more uniform and egalitarian health system

The National Health Act, which became law in 2004, has been the government’s chief response to the continuing health care challenges. It is intended, among other matters, “to remedy the inequities of the past in the distribution of health care and to create a national health system that is patient centred and for the good of all.” The NHA has been described as “the overarching piece of legislation that enables the establishment of a national health system encompassing public, private and non-governmental providers of health services.”²⁹

The National Health Act is the current government’s chief legislative response to the daunting and urgent health care challenges of the post-apartheid era.

Some of the legislation’s key provisions require that: free basic health services are available in the public system, no South African can be refused emergency medical treatment, and new health governing structures be set up (a requirement designed to ensure better coordination between the national, provincial and district levels).

The legislation also has a strong redistributive bent. Among its primary objectives are:

- “the progressive realisation of the right of the people of South Africa to have access to health care services;”
- “the fundamental goal of equity;” and
- “to provide uniformity in respect of health services across the nation.”

Commentators and stakeholders have highlighted the importance of the NHA in providing “a framework for a structured uniform health system . . . taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services”.³⁰

Unfortunately, South Africa’s pre-existing GATS commitments conflict with key elements of the new health legislation. The risk is that foreign for-profit health service corporations, through their governments, will exploit this conflict to frustrate and undermine the implementation of the new legislation.

CONFLICTS BETWEEN THE NHA AND THE GATS

Certificates of need

The starkest area of conflict between the National Health Act and the GATS is between the legislative requirements for “certificates of need” and GATS Article XVI, Market Access.

The “certificate of need” is the main policy instrument in the NHA for achieving greater uniformity and equality in the health care system. Within two years, every health establishment in the country – whether public or private – must have a certificate in order to operate. Section 36 of Chapter 6 of the legislation states:

“36. (1) A person may not-

(a) establish, construct, modify or acquire a health establishment or health agency;

(b) increase the number of beds in, or acquire prescribed health technology at, a health establishment or health agency;

(c) provide prescribed health services; or

(d) continue to operate a health establishment or health agency after the expiration of 24 months from the date this Act took effect, without being in possession of a certificate of need.”³¹

The requirement for a certificate of need applies whether the establishments are public, private “for-profit” or private “not-for-profit” and whether providing “in-patient” or “out-patient” services. The act defines “health establishment” as “the whole or part of a public or private institution, facility, building or place, whether for profit or not, that is operated or designed to provide inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventative or other health services.”³²

This system gives public health authorities a badly needed planning tool to begin to address inequality and misallocation of health resources, particularly by the private sector. The NHA gives the health minister the authority to issue or refuse a certificate based on community needs and to attach conditions when a certificate is granted, such as requiring that

health establishments train community health care professionals or agree to provide public health services used by low-income communities.

The requirement for a “certificate of need” for health establishments is a badly needed planning tool to address inequality and misallocation of resources.

By international health policy standards, the NHA is fairly moderate and typical in its approach to regulating the health sector. Similar needs tests are applied, whether formally or on an ad hoc basis, by health authorities around the world.

The legislation resorts to these well-established policy tools to confront the national reality that public efforts are desperately needed to redistribute scarce health resources that are still disproportionately directed to rich, urban and predominantly white South Africans. Predictably, however, the NHA has encountered criticism from private, for-profit providers and elements of the medical profession who feel threatened by the planning prerogatives vested in health authorities.³³

Evidently, many health establishments that are covered by South Africa’s GATS commitments, such as general practitioners’ offices, nursing clinics, diagnostic clinics, and out-patient clinics, will be required to have certificates of need. Although hospitals, which involve institutionalized nursing care, are not covered by South Africa’s GATS commitments, certain services provided within hospitals on an out-patient basis are covered. This coverage could complicate the administration of the certificates of needs even for hospitals.

Market access: GATS Article XVI

GATS Article XVI, Market Access, requires South Africa to accord services and service suppliers of other WTO Members treatment “no less favourable than that provided for under the terms, limitations and conditions set out in its Schedule (Art. XVI.1).” Under Article XVI.2, where a market access commitment is given, as it has been by South Africa for a wide range of health and health-related services, South Africa cannot maintain or adopt certain measures, unless otherwise specified in its Schedule.

In sectors where commitments are taken, GATS Article XVI disallows six types of measures, which are described in the six sub-paragraphs of Article XVI.2. Governments cannot “maintain or adopt” the following types of measures:

- “Limitations on the number of service suppliers, whether in the form of numerical quotas, monopolies, exclusive service suppliers or the requirements of an economic needs test.” (For example, restricting the number of medical specialists in a particular region or providing certain out-patient services exclusively through government monopolies or contracts with exclusive service suppliers).

- Restrictions on the total value of service transactions or assets (for example, private clinics are authorised to perform only X million rand of certain health services or must have assets not exceeding X million rand).
- Restrictions on the total number of service operations or the total quantity of service output (for example, limiting or rationing the number of day surgeries or diagnostic imaging services performed in a particular region).
- Restrictions on the total number of natural persons that may be employed in a particular service sector or that a service supplier may employ (for example, limits on the total numbers of doctors or nurses employed in a health district).
- Restrictions on or requirements for certain types of legal entity or joint venture for the supply of a service (for example, a requirement that a foreign physician must enter into a joint venture with a local physician or local community-based clinic to enter the market).
- Limitations on the participation of foreign capital in terms of maximum percentage limit on foreign shareholding or the total value of individual or aggregate foreign investment (for example, limiting foreign ownership of private health clinics to 49%).

Significantly, all these types of restrictions are disallowed even if they are non-discriminatory (that is, applying equally to foreign and domestic services and suppliers).³⁴ Furthermore, such restrictions are not to be adopted or maintained “either on a national or a regional basis.” This means that measures taken by municipalities or local health districts within their own jurisdictions are also restricted by the GATS.

The measures prohibited under Article XVI.2 include “limitations on the number of service suppliers, whether in the form of numerical quotas, monopolies, exclusive service suppliers or the requirements of an economic needs test (Article XVI.2(a)).”

Certificates of need conflict with GATS Market Access rules.

Certificates of need clearly violate the terms of sub-paragraph (a) by applying a form of economic needs testing to the approval of new or the expansion of existing health establishments. While the GATS does not formally define the term, an “economic needs test,” is simply a government measure which restricts the entry of service suppliers based on an assessment of the needs in the market.

Basing decisions about the allocation of health resources on a public assessment of health needs rather than leaving these solely to private

market forces is, of course, precisely what the certificate of needs system is intended to do. It provides democratically-elected governments and public health officials with a tool to achieve more uniform quality in the health care system and more equitable access to health care services by shifting providers and resources to where the need is greatest. Its function is basically redistributive. It advances overall health policy goals by limiting growth in areas or markets that are already well-served, while encouraging expanded services to poorly-served regions or populations.

From a GATS perspective, such measures are illegal barriers to market entry. They can only be maintained in committed sectors if they are listed as “limitations” in the country’s GATS schedule. The NHA, of course, did not yet exist in 1994 when South Africa made its GATS commitments covering health services. Consequently, neither the legislation in general nor the certificates of need in particular are protected by limitations in the schedule.

While relatively few WTO member governments made commitments covering health services as extensive as those made by South Africa, some of those that did included limitations for economic needs tests for health establishments that are similar to the South African certificates of need. The United States, for example, made commitments covering hospital services, but the U.S. schedule contains an exception that states: “Establishment of hospitals or other health care facilities, procurement of specific types of medical equipment, or provision of specific types of medical procedures may be subject to needs-based quantitative limits.”³⁵

Even though South Africa has not covered hospital services per se, the U.S. reservation is further evidence that the application of certificates of need to health establishments that are covered by South Africa’s commitments – such as general practitioners’, psychiatric practices, mobile clinics, satellite clinics, nursing clinics and even hospital out-patient services – violates the GATS.

Other GATS Article XVI.2 issues

While sub-paragraph (a) provides the clearest example of a GATS inconsistency, there are other potential conflicts between certificates of need and the GATS Article XVI.2.

The NHA gives the Director-General, the head of the national health department, broad discretion to administer certificates of needs to limit growth in health establishments, types of medical procedures, licensing of equipment, and other services, in certain areas until more needy areas or populations are better served. Attaching restrictions on the numbers of health professionals employed in a region or by a particular health establishment, for example, could conflict with the Article XVI.2(d) prohibitions of limits on the number of natural persons “that may be employed in a particular service sector or that a service supplier may employ.”

The certificates of needs system also requires government approval to “acquire prescribed health technology.” Such a requirement arguably violates XVI.2 (c) by limiting the “total number of service operations or the total quantity of service output” especially for specialized, technology-dependent services such as diagnostic imaging.

Article XVI.2 (e) prohibits “restrictions on or requirements for certain types of legal entity or joint venture for the supply of a service.” This would prevent, for example, a requirement that a foreign physician must enter into a joint venture with a local physician or local community-based clinic to enter the market. It could also create problems for policies that seek to limit the growth of the for-profit sector, while encouraging a greater role by the public or not-for-profit sector (which are specific forms of “legal entity”). The exercise of this type of discretion, while not required, is clearly authorised by the national health legislation. Moreover, the disproportionate growth of the private for-profit sector, which commands a large share of health resources while serving only a small segment of the South African population, is recognised as a distortion within the existing health care system.

These are not merely technical inconsistencies. A foreign-owned medical services provider could defeat the purpose of the South Africa’s health legislation by establishing a clinic in an already well-served neighbourhood or market niche, as well as by hiring doctors, nurses and other medical personnel away from higher-priority regions or health services. South African governments, at all levels, could not use the most important policy levers, which are contained or authorized in the current law, to curb such practices without violating the country’s GATS market access commitments.

National treatment: GATS article XVII

The second major GATS rule applying to expressly listed sectors is Article XVII, national treatment. It obliges governments to “accord to services and services suppliers of any other Member, in respect of all measures affecting the supply of services, treatment no less favourable than that it accords to its own like services and services suppliers.”³⁵ This powerful rule applies to all sectors and sub-sectors listed in a country’s schedule.

GATS National Treatment rules create a host of regulatory issues and problems for South Africa in the health care sector.

The application of national treatment to the health services covered by South Africa’s specific commitments creates a host of regulatory issues and problems.

Local control and decision-making

In most countries, there is a strong tradition of local accountability and control in the delivery of health services. Such policies cut against the grain of the national treatment rule. For example, requirements that a majority

of senior management or boards of directors of private health clinics come from the local community or district would discriminate against foreigners, violating national treatment. Similarly, requiring that a foreign health providers form a partnership with a local, community-based organisation in order to provide health services would also violate national treatment.

Local training and technology transfer

Requirements that foreign health service providers transfer technology or train locals are also GATS national treatment violations. The GATS scheduling guidelines make clear that such measures must be listed as non-conforming limitations or eliminated.³⁷ There are no limitations protecting such non-conforming measures in South Africa's schedule. This means, for example, that if the government or a local authority chose to negotiate with a foreign service provider, conditioning its entry into the market on a commitment to transfer health technology or to train locals, the enforcement or implementation of such commitments could be contested as GATS-inconsistent.

Subsidies

Most trade treaties, including the General Agreement on Tariffs and Trade (GATT) and the North American Free Trade Agreement (NAFTA), exclude subsidies from the national treatment obligation³⁸. The GATS national treatment rule, however, applies fully to subsidies. There is a surprisingly low level of awareness among government officials that the GATS non-discrimination rules apply to public spending programmes.

The GATS national treatment rule entails that, in covered sectors, government subsidies, preferential loans, or loan guarantees that are available only to South African service suppliers, or exclusively to community-owned or controlled entities would be exposed to challenge.

One of the major hurdles confronting the South African health care system is the loss of skilled health professionals to the private sector where earnings and career opportunities are generally superior. Public incentives or subsidies to retain or attract health professionals to public or not-for-profit clinics could discriminate against foreign private clinic service suppliers, thereby violating national treatment. Unlike many other WTO member governments, South Africa does not have a GATS limitation that protects its policy flexibility with regard to subsidies.

Black Economic Empowerment

Black Economic Empowerment (BEE) is an affirmative action program identified by the African National Congress government as a major vehicle for addressing the economic injustices of apartheid.³⁹ The Broad-Based Black Economic Empowerment Act of 2003 defines BEE as: "the economic empowerment of all black people including women, workers, youth,

people with disabilities and people living in rural areas through diverse but integrated socio-economic strategies that include, but are not limited to:

- increasing the number of black people that manage, own and control enterprises and productive assets;
- facilitating ownership and management of enterprises and productive assets by communities, workers, cooperatives and other collective enterprises;
- human resource and skills development;
- achieving equitable representation in all occupational categories and levels in the workforce;
- preferential procurement; and
- investment in enterprises that are owned or managed by black people.⁴⁰

Obviously, the impetus of BEE is directly at odds with the GATS national treatment rule. As a matter of fundamental principle, government measures favouring ownership by, transfer of assets or technology to, and training for black South Africans - indeed, any set of South Africans - discriminate against foreigners. They therefore violate the national treatment provision.

The BEE Act is applicable to all sectors of the South African economy, including health. There has, however, been little black economic empowerment in the health sector thus far. As an official document notes, "BEE is made more difficult by the concentration in the supply side and the funding side of the private sector."⁴¹ The private health care sector has historically been white-controlled. According to one source, "Black players hold only about 0.5% of the private health-care industry, which is estimated to be worth about R100bn in total."⁴²

On July 11, 2005 the government unveiled a draft charter for the health sector. The draft charter lays out fairly ambitious targets for black ownership in the health sector, setting an immediate target of "at least 26% ownership or control by black people," rising to 35% by 2010 and 51% by 2014.⁴³ The draft charter also mandates "putting in place programmes that result in the broader representation of black persons in the workplace. It is the target at all levels in the chain that by 2010 the workplace will be 60% black across the value chain and will comprise 50% women. Further, it is the target that by 2014 the workplace will be 70% black across the value chain and shall comprise 60% women."⁴⁴

The principles of Broad Based Black Economic Empowerment "are applicable to all those firms and/or individuals that conduct business or

economic activity in the health sector whether for profit or otherwise.”⁴⁵ Enforcing BEE targets on foreign service providers in the health sector could violate the GATS national treatment rule.

One policy lever for enforcing BEE is, however, insulated from GATS challenge. Because GATS Article XV excludes government procurement from national treatment, affirmative action related to access to government procurement remains GATS-consistent. The draft charter states that: “The eligibility of stakeholders that do not implement the Charter for state contracts and contracts with other parties to the Charter would be reduced or precluded altogether depending on the circumstances.”⁴⁶

But many aspects of the charter - setting enforceable targets for black ownership or management, requiring foreign service suppliers to train locals as a condition for operating in the South African market, or requiring foreign investors to devote a “fixed proportion of their annual income on social responsibility projects” - are all problematic from a GATS national treatment perspective in covered health services sectors. BEE policies could also run afoul of GATS Article XVI. For example, a requirement that 10% of a service investment be owned by black South Africans is effectively a limit of 90% on foreign ownership, and therefore a violation of the market access rule.

OPTIONS TO REDRESS GATS CONFLICTS

The National Health Act and the government's health policy currently violates South Africa's 1994 GATS commitments in numerous ways. As demonstrated, the "certificates of need" system directly conflicts with GATS Article XVI. More generally, GATS prohibitions against limiting the numbers or activities of private sector service providers interfere with public policies that aim to allocate health resources more equitably and "to promote equity of access to health care services among all South Africans, between urban and rural areas, between rich and poor people, and between the public and private sectors."⁴⁷

Other health planning initiatives, such as those designed to increase local decision-making and control, technology transfer, and affirmative action programmes, contradict the national treatment rights granted to foreign service providers under GATS Article XVII. Furthermore, if negotiations already underway (under GATS Article VI.4) to develop new restrictions on non-discriminatory government regulation are concluded, South Africa's commitments covering health services will prove to be even more regressive and problematic

The approaches embodied in South Africa's health policies and its 1994 GATS commitments are incompatible. Given the urgency of South Africa's public health challenges and the pressing need to transform its current highly inequitable health system, it would be a travesty if South Africa's policy initiatives were halted or reversed in order to conform to the GATS. Moreover, South Africa's supreme law, the constitution, not only mandates the protection of health as a human right; it stipulates that this and other constitutional responsibilities of the state may not lawfully be fettered by any other law or agreement.⁴⁸

There are several approaches for resolving the conflict so as to maintain South Africa's much-needed health initiatives. Accordingly, the most reasonable and constitutionally valid means to resolve the conflict is to bring South Africa's GATS commitments into conformity with the country's health policy initiatives. There are several possible options to bring the GATS commitments into line.

The “wait-and-see” approach

The first option is to implement the National Health Act and other health policy initiatives as planned and deal with any potential GATS issues or litigation if or when they arise.

For diplomatic reasons, most governments may hesitate to bring such a challenge to the WTO dispute settlement system, fearing the international controversy that would likely result. Under the NAFTA investment chapter, most bilateral investment treaties, and the planned U.S.-Southern African Customs Union Free Trade Agreement, investors can bring disputes directly to investor-state arbitration. The WTO dispute settlement system differs in that it is strictly a government-to-government process

Certain foreign governments, even if they are eager to promote the interests of their own health service corporations in South Africa, may also be reluctant to throw the spotlight on their own potentially GATS-inconsistent health policies. For example, the U.S. Congress is currently debating the extension of a recently expired 18-month ban on the opening of specialty hospitals. Congress put the ban in place because of lawmakers' concerns that specialty hospitals were cherry-picking the most profitable services and harming public and not-for-profit full-service hospitals that were left to provide more costly services.⁴⁹ If U.S. officials brought a case against South Africa's certificates of need policies, it would risk raising the ire of U.S. lawmakers about potential WTO interference with their own policy prerogatives.⁵⁰ Trade officials from other WTO member countries may also be reluctant to draw attention to their own country's vulnerabilities.

There are, however, serious pitfalls with the wait-and-see approach. Diplomatic concerns did not prevent the U.S. government from championing the highly unpopular cause of global drug companies in their aggressive campaign to overturn provisions in the South African Medicines Act of 1997, which were designed to lower the costs of pharmaceuticals urgently needed to treat citizens with HIV-AIDS.⁵¹ The U.S. administration threatened South Africa with trade and economic sanctions if it did not withdraw the initiative to provide cheaper generic versions of patented drugs. Only public outrage in South Africa and abroad forced the global pharmaceutical manufacturers to withdraw their legal challenge to the legislation and for the U.S. government to downplay its threat to bring trade action against South Africa.⁵²

While it might appear hypocritical for the U.S. to attack South African health policies (such as the certificates of need) that are similar to regulations its own states and Congress apply domestically, such double-standards are not unusual in trade litigation. U.S. trade negotiators were shrewd enough to insulate their domestic health needs tests against GATS challenge, while South African negotiators did not.

In the event of a dispute, the South African government could also turn to the general exceptions clause, GATS Article XIV, to attempt to defend

challenged measures. To successfully invoke this exception, the South African government would have to demonstrate, among other things, that no alternative GATS-consistent or less GATS-inconsistent measure was reasonably available to it to achieve its health policy objectives.⁵³ Because, in the abstract, without reference to real-world costs or political realities, there is almost always a less trade restrictive measure available, it would be unwise to rely on this exception.

Finally, most WTO member governments have not made as extensive commitments in health services as South Africa has. These governments could therefore be more easily persuaded to act on behalf of their multinational service corporations, without fear of domestic policy repercussions. Even the threat of WTO litigation could be used to apply pressure on South Africa and to distort its health policy in favour of foreign commercial interests. Sooner or later, because of the stark inconsistency between the NHA and the GATS, disputes are almost certain to arise.

Withdraw South Africa's GATS health commitments

A second option is for South Africa to withdraw its 1994 GATS commitments covering health services. The GATS provides a means for governments to withdraw previously-made commitments, as long as they are prepared to compensate other governments whose service suppliers are allegedly adversely affected.⁵⁴ South Africa would be required to negotiate increased GATS coverage in other sectors to compensate affected WTO member governments for their service suppliers' lost "market access" in health services.

Withdrawing South Africa's GATS commitments covering health services removes the GATS threat at its source, but would require negotiation with other WTO members seeking trade compensation.

Under GATS Article XXI South Africa would be required to:

- notify the WTO prior to the intended granting of monopoly rights;
- consult with other member governments who believe their service suppliers are affected; and
- negotiate with them to try to arrive at trade-related compensatory adjustment. If no mutually-acceptable agreement is reached, the matter could be referred to WTO arbitration for resolution.

This procedure to modify GATS schedules was invoked for the first time in July 2003 by the European Union. The European Communities (EC) gave notice that it intended to modify or withdraw GATS commitments. The changes relate to the 1995 and 2004 enlargements of the EC to include new member countries.⁵⁵ A number of governments, including the United States, requested negotiations with the EC with a view to

reaching agreement on any necessary compensatory adjustment. These talks are still underway.

Withdrawing the GATS commitments has the advantage that it removes the threat to the National Health Act and other health measures at its source. This approach has obvious drawbacks, however. South Africa would be expected to make new GATS commitments in other sectors. It is difficult to estimate in advance how large these commitments would have to be, or what other important areas of policy flexibility might be affected.

Nevertheless, this is a viable option to resolve the immediate GATS threat to the National Health Act and related health policies. If South Africa decides to pursue this option, the sooner it initiates the process the better. Awaiting the conclusion of the Doha Round, where it faces strong pressure to pledge additional GATS commitments, would weaken its ability to negotiate reasonable compensation.

Another consideration recommends this approach. While withdrawing the South African commitments is a limited and technical response, it has broader significance. It defies the logic of progressive liberalization and, accordingly, would likely be strongly resisted by GATS proponents and beneficiaries. But if a major developing country such as South Africa were to give notice that it intended to withdraw GATS commitments because of health and development policy concerns, that move would send an important and salutary message that the GATS approach to health services is flawed and needs to be changed.

Such leadership is sorely needed to inspire collective action by citizens and governments in as many countries as possible to confront the threats posed by the GATS to progressive health policies.

Confronting the inconsistency between the GATS and progressive health policy

As already noted, South Africa's health legislation is not draconian or highly unusual in the policy tools it employs. Similar measures are in widespread use in the health sectors of both developed and developing countries. The only exceptional feature of the South African situation is the magnitude and urgency of the health crises the country confronts. Therefore, the multiple conflicts between the NHA and the GATS are not an indictment of South African policy, but of the intrusive overreach of the trade agreement.

This dissonance suggests a final course of action. South Africa, along with other countries in the same situation, should address the more fundamental conflict between the commercialising imperatives of the GATS and public policies to ensure accessible and equitable health services as a matter of human rights.

Collective action is needed to address the fundamental threats the GATS poses to progressive health policies world-wide.

This is not just a matter, as sometimes portrayed, of an international treaty inevitably infringing on domestic sovereignty. All international treaties affect domestic sovereignty. At issue are the goals and effects of this specific treaty. Certain international treaties enshrine the right to health and universal access.⁵⁶ Such treaties, though they would also, in some sense, impinge on South Africa and other countries' sovereignty, reinforce, rather than diminish, the goals of the domestic legislation and South Africa's constitutional protections of the right to health.

Nor should the health policy impacts of the GATS be judged solely against the ability of governments, if they are savvy and powerful enough, to shield their policies from particular GATS provisions or to limit their application through careful scheduling. It is fair rather to evaluate these impacts when, as is intended over time, its provisions are fully applicable to the health sector.⁵⁷

The multiplicity and variety of threats posed by the GATS to South African health policies aimed at achieving access and equity illustrate deep, structural flaws in the agreement - problems that render it detrimental to a variety of public service systems and to public interest regulation. These problems stem directly from the text of the GATS, the "black-letter law" of the treaty.

This suggests that instead of the current negotiations to broaden and deepen GATS coverage, there should be a thorough and detailed assessment of the treaty's defects from a health policy and public interest perspective. Such an assessment should lead to proposals for concrete changes to remedy these flaws through joint international action involving health and other essential services. In the meantime, the ongoing negotiations to expand GATS coverage should be shelved.

The treaty's structural flaws must be addressed. At a minimum, this would require that the GATS be amended to effectively exclude mixed (public-private) social service systems from the agreement. GATS Article XVI (Market Access) should also be changed so that it no longer constrains the non-discriminatory exercise of regulatory authority. The negotiations to extend GATS restrictions to other forms of non-discriminatory regulation (under GATS Article VI.4) should be abandoned.

Even with these fundamental changes, it is highly questionable whether the GATS is an appropriate agreement to regulate health and other essential services internationally. It has been too irrevocably shaped by narrow, commercial interests.

Bringing South Africa's GATS obligations into line with its new national health legislation and other health policy initiatives is therefore just the first step in ensuring more democratic and progressive governance frameworks for human and social development. If services are to be regulated multilaterally, the GATS should eventually be replaced by a far more balanced set of international rules that validates and augments public interest regulation, universal health and social services, environmental protection, and other public and social goods.

ENDNOTES

1. Annex 1 of the Marrakesh Agreement Establishing the World Trade Organization includes fifteen multilateral agreements regulating various aspects of trade in goods, services and intellectual property. The GATS occurs in Annex 1B. See *The Results of the Uruguay Round: The Legal Texts*, Geneva: World Trade Organization, 1995.
2. The rules governing dispute settlement in the WTO are set out in Annex 2 of the Marrakesh agreement, the "Understanding on Rights and Procedures Governing the Settlement of Disputes." See note 1 above.
3. WTO Secretariat, "An Introduction to the GATS," October 1999, p. 1.
4. The GATS was negotiated over eight years from 1987 to 1994. The treaty was finalised in April 1994 and entered into force on Jan 1, 1995. The African National Congress, which won the country's first democratic elections on April 14 1994, had been formally involved in major government decisions through the Transitional Executive Council since December 1993. But given the challenges of this historic transition, it is understandable that the implications of health services commitments under a complex and then obscure sub-agreement of the World Trade Organization were neither fully understood nor adequately scrutinised by the new democratic government.
5. The complexity of the GATS also confounded academic health specialists studying the impacts of the GATS health services commitments. One study, while cautioning that the GATS could jeopardise policies to achieve equitable health outcomes, missed the significance of South Africa's existing commitments. The study mistakenly concluded that "it seems safe to say the country has yet to undertake effective commitments to trade in health services." Susan Cleary and Stephen Thomas, "Mapping Health Services Trade in South Africa," University of Cape Town, Trade and Industrial Policy Strategies, Working Paper 8, July 2003, p. 13.
6. Certain GATS rules - the key being the Most-Favoured Nation treatment article - are unconditional (or "top-down") and apply across-the-board to all sectors irrespective of whether commitments have been taken.
7. South Africa: Schedule of Specific Commitments, GATS/SC/78, 15 April 1994, pp. 2-5.
8. The meaning and policy implications of national treatment and market access commitments are discussed in section 5, Conflicts between the NHA and the GATS.
9. It is not clear why government negotiators believed that it was not technically feasible to provide physiotherapy or paramedical services through mode 2, consumption abroad.
10. Riaz Tayob of the Southern and Eastern African Trade Information and Negotiations Institute points out that "South African nurses typically perform more complex functions than nurses in the north." Personal correspondence, Sept. 26, 2005.
11. It is described as "horizontal" because it applies across-the-board to all the sectors and sub-sectors listed in the schedule.
12. See South Africa: Schedule of Specific Commitments, GATS/SC/78, 15 April 1994, pp. 2-5
13. One of South Africa's services negotiators made this comment in a meeting, with international NGOs (at which the author was present) in Geneva on June 29, 2005. South African trade officials have made similar assertions on previous occasions.

14. See Scott Sinclair, *GATS: How the World Trade Organization's New "Services" Negotiations Threaten Democracy*, Ottawa, Canadian Centre for Policy Alternatives, 2000, pp. 67-75.
15. *Services Sectoral Classification List*, Note by the Secretariat, MTN.GNS/W/120, 10 July 1991.
16. World Trade Organization, "Health and social services," in *Services: Sector by sector*, at http://www.wto.org/english/tratop_e/serv_e/health_social_e/health_social_e.htm.
17. Since the mid-1990s, the provisional CPC has been superseded by other more updated and elaborate UN statistical classification systems, but it remains the legal basis for defining GATS commitments. The provisional CPC, and other UN classification systems, are available on-line at the United Nations Statistical Classifications Main Page, <http://unstats.un.org/unsd/class/default.htm>.
18. United States – Measures Affecting the Cross-border Supply of Gambling and Betting Services, Report of the Appellate Body, 7 April 2005, para. 172.
19. An explanatory note in the provisional CPC describes medical and dental services as "Services chiefly aimed at preventing, diagnosing and treating illness through consultation by individual patients without institutional nursing, except nursing provided by hospital out-patient clinics (for a part of the day)."
20. From a series of e-mail exchanges in late 2003 and early 2004 between Jeff Rudin of the South African Municipal Workers Union and Department of Trade and Industry officials it is clear that senior services trade officials had not previously considered the issue of a potential inconsistency between the National Health Act and the 1994 GATS commitments.
21. This means that "services of medical laboratories" are excluded from sub-class 93122 and therefore are not covered by South Africa's GATS commitments.
22. Department of Health, Republic of South Africa, "White Paper for the Transformation of the Health System in South Africa," April 1997, Chapter 3, available at www.doh.gov.za/docs/index.html.
23. "The charter of the public and private health sectors of the Republic of South Africa," Draft, South African Ministry of Health, July 2005. para. 2.2.3.
24. Steve Berry, "HIV and AIDS in South Africa," September, 2004, www.avert.org/aidssouthafrica.htm.
25. UNAIDS estimates AIDS-related deaths in South Africa at 370,000, with a range from 270,000 to 520,000, cited in "Reporting AIDS: An analysis of media environments in Southern Africa," Panos Institute, London, 2005, chapter 4.
26. "The HIV/AIDS epidemic worsens—on a daily basis—the circumstances that give rise to the need for the transformation of the health care system. We recognise that the HIV/AIDS epidemic exacerbates poverty and inequality, placing unsustainable pressure on health establishments." Joint Submission of the AIDS Law Project and the Treatment Action Campaign, to the Portfolio Committee on Health: Public Hearings on the National Health Bill, B32—2003, 31 July 2003.
27. See Section 4 of this paper and the references in notes 46 and 47.
28. Quoted in "HIV and AIDS in South Africa," *supra*, note 21, www.avert.org/aidssouthafrica.htm.

29. Cleary, et al. *supra*, note 5.
30. *Joint Submission of the AIDS Law Project and the Treatment Action Campaign, to the Portfolio Committee on Health: Public Hearings on the National Health Bill, B32—2003*, 31 July 2003.
31. *Republic of South Africa, No. 61 of 2003, National Health Act, 2004, Government Gazette, v. 469, Cape Town 23, July 2004, no 26595.*
32. *Ibid.*, "Definitions."
33. *In February 2004, the South African Medical Association (SAMA), representing doctors, organized a march on Parliament to protest against the then-proposed certificate of need system.*
34. *It is often asserted that GATS rules merely require governments to treat foreign services and service providers fairly, leaving governments free to regulate as they wish so long as their laws do not discriminate. In the case of GATS Article XVI, this assertion is clearly false.*
35. "U. S. Schedule of Commitments under the General Agreement on Trade in Services, with explanatory materials," *United States International Trade Commission, May 1997*. p. 69.
36. GATS Article XVII, *National treatment.*
37. "Technology transfer requirements, e.g. skilled foreign employees required to provide training to locals." are listed as an example of "some of the most common forms of national treatment restrictions." See "Revision of Scheduling Guidelines, Note by the Secretariat," *World Trade Organization, Committee on Specific Commitments, March 5, 1999, p. 10.*
38. *By covering subsidies the GATS negotiators departed from the usual approach under other international trade agreements. The NAFTA and the GATT 1994 rules on goods, for example, both exempt subsidies from national treatment. NAFTA's services chapter does not apply to subsidies and grants (NAFTA Article 1201.2d) and NAFTA's investment rules specifically exclude subsidies and grants from national treatment and most-favoured nation (NAFTA Article 1108.7).*
39. "When the African National Congress (ANC) came to power in South Africa in 1994, it identified black economic empowerment as a major vehicle for addressing the economic injustices of apartheid. However, questions have been raised as to whether the current process has not resulted in the enrichment of an elite few rather than empowerment of the millions who still remain excluded from participating in the economy." *Republic of South Africa, "BEE: Ten Years Down the Line, in "Doing Business in South Africa," http://www.southafrica.info/doing_business/trends/empowerment/bee-10years.htm*
40. *Republic of South Africa, BEE Act No 53 of 2003, Definitions.*
41. "The charter of the public and private health sectors of the Republic of South Africa, Draft," *South African Ministry of Health, July 2005.*
42. "Equity Targets May scare off Foreign Health Companies," *Business Day, Dec. 1, 2004.*
43. "The charter of the public and private health sectors of the Republic of South Africa, Draft," *South African Ministry of Health, July 2005. paras. 3.4.1 to 3.4.3.*

44. *Ibid.*, para. 3.2.11.
45. *Ibid.*, para. 2.4.1.
46. *Ibid.*, para. 3.5.2
47. Department of Health, Republic of South Africa, "White Paper for the Transformation of the Health System in South Africa," April 1997, Chapter 3, available at www.doh.gov.za/docs/index.html.
48. Cf. "[Recognizing] generally, that the powers and functions, roles and responsibilities of the national, provincial and local spheres of government and of the legislature, the executive and the judiciary are as set out in the Constitution and that such powers and functions, roles and responsibilities may not lawfully be fettered or restricted by any other law, agreement or transaction;" Para. 6. , "The charter of the public and private health sectors of the Republic of South Africa, Draft," South African Ministry of Health, July 2005.
49. See David Armstrong, "A Surgeon Earns Riches, Enmity By Plucking Profitable Patients: Specialty Hospitals Go Public, Sparking Ire in Rapid City; Older Facility Faces Losses, Clash Over Anonymous Letter," *The Wall Street Journal*, August 2, 2005; Page A1.
50. The ban is arguably shielded from successful GATS challenge by the U.S. limitation for "needs-based quantitative limits" referred to in section 5.2 of this paper.
51. The Medicines Act provides for the possibility of "compulsory licensing" and "parallel importing" to reduce the costs of drugs. Compulsory licenses are granted by governments to permit licensees to use patented intellectual property upon payment of royalties to the patent holder. By introducing competition, compulsory licenses dramatically lower the costs of drugs. Parallel importing involves purchasing drugs from a third party in another country, rather than directly from the manufacturer, to take advantage of lower prices. Both practices are permitted under the WTO TRIPS agreement, subject to certain restrictions. Due to continuing political pressure on South Africa from global pharmaceutical companies and their home governments, the regulations giving effect to these flexibilities remain stalled.
52. In February 1998, a group of 39 pharmaceutical companies took the government of South Africa to court over its Medicines and Related Substances Act. The main issue was Amendment 15(c) which would allow TRIPS-compliant compulsory licensing and parallel imports of medicines in South Africa. On April 19, 2001, the pharmaceuticals companies, under intense international pressure, dropped their case. For further information on this dispute and ongoing U.S. pressure, see the web sites of the Consumer Project on Technology, , the Treatment Action Campaign www.tac.org.za, and the AIDS Law Project at <http://www.alp.org.za> . See also Robert Weissman, "AIDS and Developing Countries: Facilitating Access to Essential Medicines, Foreign Policy in Focus, Volume 6, Number 6, February 2001.
53. To successfully invoke this exception, defendant governments bear the burden of demonstrating that a challenged measure is aimed at one of the specific legitimate objectives listed in Article XIV, that it satisfies the qualifying language of the specific exception invoked, and that it meets the conditions in the introductory chapeau of Article XIV that the measure is neither "arbitrary or unjustifiable discrimination" nor a "disguised restriction on trade in services." GATT and WTO panels and the Appellate Body have been strict in their approach to the applicability of general exceptions. For a discussion of these three elements in relation to GATT XX see Jon R. Johnson, *International Trade Law*, (Concord, Ontario, 1998) pp. 66 ff.

54. GATS Article XXI allows countries to modify or withdraw a specific commitment after three years from the time the initial commitment is made.
55. The 1994 enlargement increased the EU from 12 to 15 members. On May 1, 2004, an additional 10 countries joined the EU, and it now consists of 25 members.
56. For example, Article 25.1 of the Universal Declaration of Human Rights affirms that "Everyone has the right to a standard of living adequate for the health of himself and of his family including food, clothing, housing, medical care and necessary social services. This right is further elaborated in the International Covenant on Economic, Social and Cultural Rights which recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."
57. "The adequacy of an agreement such as the GATS should not be tested against the capacity of members individually to limit the applicability of its provisions. On the contrary, one should assume that all of its provisions are fully applicable and should check to what extent the provisions can be adjusted to domestic regulatory concerns." David Luff, "Regulation of Health Services and International Trade Law," in Aaditya Mattoo and Pierre Sauvé, eds. *Domestic Regulation and Service Trade Liberalization*, World Bank/Oxford University Press, 2003, p. 191.

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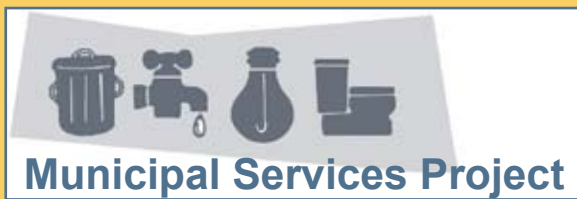
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