

ABSTRACT

Important aspects of South Africa's flagship health legislation, the National Health Act, conflict with legally binding commitments the former apartheid regime negotiated under the World Trade Organization's General Agreement on Trade in Services. This trade treaty conflict threatens to undermine the legislation and, if left unresolved, would make meeting the health needs of the majority of the population 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 worldwide warning that health policy-makers, governments and citizens need to be far more attentive to international treaties governing services and ongoing negotiations to expand them. Hopefully, this increased awareness will spur action to ensure that South African health policy initiatives can proceed without World Trade Organization's General Agreement on Trade in Services interference.

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INTRODUCTION^{a1}

In July 2004, South Africa (SA) passed its long-awaited National Health Act (Health Act).² This legislation, enacted after nearly a decade of debate, was designed to rectify severe health inequities resulting from apartheid and to combat mounting public health crises, including the HIV 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 globalisation, they are not.

Unlike its GATT predecessor, the new WTO is about considerably 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.^b These rules are enforced through a binding dispute settlement system, backed up by trade sanctions.^c

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 SA 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 significant.

SOUTH AFRICA'S GATS COMMITMENTS COVERING HEALTH SERVICES

GATS which came into force on January 1, 1995, is a novel trade treaty. 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.

The scope of the GATS is very 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 also defines ‘trade in services’ broadly 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, including through foreign investments.

a This chapter is based on a longer paper, commissioned by the South African Municipal Workers' Union (SAMWU): Scott Sinclair, “The GATS and South Africa's National Health Act: A Cautionary Tale” first published by the Canadian Centre for Policy Alternatives (<http://www.policyalternatives.ca>) in November 2005 and re-published in South Africa by the Municipal Services Project (<http://www.queensu.ca/msp>) in May 2006.

b 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. World Trade Organization, *The Results of the Uruguay Round: The Legal Texts*, Geneva, 1995.

c 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, in *World Trade Organization, The Results of the Uruguay Round: The Legal Texts*, Geneva, 1995.

**Box 1:****The four GATS "modes of supply"**

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', for example 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 affecting 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

Importantly, the strongest provisions of the GATS apply only to those sectors that governments specifically agree to cover.^d 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.

In theory, each 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.

^d Certain GATS rules – the key one 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.

In practice, GATS flexibility evaporates once specific commitments are made.^e 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.

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

HOW HEALTH SERVICES ARE CLASSIFIED UNDER THE GATS

As recently as June 2005, a senior South African trade negotiator insisted that SA has made no GATS commitments covering health services.^f Examining South Africa's GATS schedule, however, clearly reveals otherwise. The misguided 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.

SA, like most other WTO member governments, followed the classification system set out in two documents – the Services Sectoral Classification List (or W-120)⁴ 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.

^e The flexibility of the GATS is limited in other ways. 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 GATS commitments. Indeed, the treaty mandates successive rounds of negotiations to broaden and deepen GATS coverage (GATS article XIX).

^f One of South Africa's services negotiators made this comment in a meeting with international non-governmental organisations (at which the author was present) in Geneva on June 29, 2005.

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."*⁵

As this description notes, a range of important health services are classified separately, under Section 1, Business Professional Services.

While SA did not make GATS commitments under section 8, Health-related and social services, it made extensive GATS commitments covering health services classified under Section 1, Professional services.

The more detailed description provided in the UN provisional CPC [See Box 2], which classifies both hospital and professional medical services under "health and social services," reveals that 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. Even certain specialised health services delivered in hospitals (through out-patient clinics or day surgery) are covered if they do not involve an overnight stay.^{g,6}

Box 2:
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).^h

^g 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)."

^h This means that "services of medical laboratories" are excluded from sub-class 93122 and therefore are not covered by South Africa's GATS commitments.



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.” For more detail see Figure 1.

Source: UN, 2006.⁵

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 a wide range of human health services have been covered and that government measures affecting these covered services, including the Health Act, are now restricted by the GATS.

SOUTH AFRICA’S NATIONAL HEALTH ACT

The Health Act has been described as “*the* fundamental piece of health legislation that will shape the future of the South African health system (emphasis in the original)”.⁸ The legislation aims to remedy past injustices by, among other things, 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 pandemic have greatly exacerbated the structural problems inherited from the apartheid era and scarce health resources are still disproportionately directed to rich, urban, and White citizens.

HEALTH POLICY CHALLENGES

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.⁹ Yet, the challenges that the South African government and society face in giving effect to these rights are daunting.

A 1997 White Paper on Health prepared by the newly-elected 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.”*¹⁰

Today, apartheid’s 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 per cent of the population) who have a high degree of access to health services and a large majority (between 75 and 80 per cent 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.”¹¹

Moreover, the HIV epidemic has greatly exacerbated the structural problems inherited from the apartheid era. It “worsens – on a daily basis – the circumstances that give rise to the need for the transformation of the health care system ... exacerbates poverty and inequality, and places unsustainable pressure on health establishments”.¹²

ACHIEVING A MORE UNIFORM AND EGALITARIAN HEALTH SYSTEM

The Health Act was passed by Parliament in late 2003, assented to by the President in July 2004 and promulgated in April 2005, bringing most sections of the Act into effect on May 2, 2005. As noted in the 2005 South African Health Review, however, significant sections of the Act ‘have not yet come into effect, pending the development of suitable Regulations’.⁸

The Health Act is intended, among other goals, ‘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 legislation 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.”²

The ‘certificate of need,’ described in section 6 of the Act, is the main policy instrument for achieving greater

uniformity and equality in the health care system. It is also ‘in all likelihood, the most controversial’ aspect of the Act.⁸ Draft regulations enabling section 6 to come into effect have still not been published.

As discussed below, potential conflicts between certificates of need and South Africa’s pre-existing GATS commitments may explain, at least in part, the government’s reticence in moving ahead with implementing this key element of the Health Act.

CONFLICTS BETWEEN THE NATIONAL HEALTH ACT AND THE GATS

The conflicts between South Africa’s health legislation and the GATS 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 GATS prohibitions against limiting the numbers or activities of private sector service providers.

CERTIFICATES OF NEED

In particular, the ‘certificate of need’ conflicts with the GATS Market Access rule (Article XVI). The basis of the new system is “the classification of health establishments into categories and then the introduction of a ‘certificate of need’ (CoN) for all such establishments.” This will allow for all health establishments, whether public or private, to be registered by the Department of Health. The controversial element is that the CoN is intended to ensure that such establishments are distributed equitably. Not only will all new or enlarged facilities have to obtain a CoN, but all established facilities would need to obtain a CoN within 24 months of this chapter coming into effect.⁸

The legislation gives the health minister the authority to grant or refuse certificates based on community needs, and to set conditions, such as requiring health establishments to service poorly-served regions or populations, or to train community health care professionals. The requirement to have a certificate applies whether the health establishments are public, private ‘for-profit’ or private ‘not-for-profit’ and whether providing ‘in-patient’ or ‘out-patient’ services.²



This system gives public health authorities a much-needed planning tool to address inequality and misallocation of health resources, particularly by the private sector. The Health Act 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.

By international health policy standards, the Health Act is fairly 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 Health Act 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.ⁱ

MARKET ACCESS: GATS ARTICLE XVI

In sectors where commitments are taken, GATS Article XVI (Market Access) disallows six types of measures, which are described in the six sub-paragraphs of Article XVI.2.¹³ Governments cannot 'maintain or adopt' the following types of measures:

- a) "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, limiting the number of medical specialists in a particular area or providing certain out-patient services exclusively through government monopolies.);
- b) Restrictions on the total value of service transactions or assets (for example, private clinics are authorised to perform only up to X million rand of certain health services);
- c) 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);

- d) 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);
- e) 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);
- f) 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%).

Importantly, all these types of restrictions are disallowed even if they are non-discriminatory (that is, even if they apply equally to foreign and domestic services and suppliers). Furthermore, such restrictions are not to be adopted or maintained 'either on a national or a regional basis' This means that such measures taken by municipalities or local health districts are also restricted.

Certificates of need clearly violate the terms of GATS Article XVI.2 (a) and (c) by limiting the approval of new or the expansion of existing health services and suppliers based on an assessment of needs. The certificate system is intended to base decisions about the allocation of health resources on a public assessment of health needs rather than leaving this solely to private market forces. 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.

ⁱ In February 2004, the South African Medical Association (SAMA), representing doctors, organized a march on Parliament to protest against the proposed certificate of need system.

Yet, 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 United States (US), for example, made commitments covering hospital services. But the US 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.”¹⁴

The South African schedule contains no comparable exception that would protect certificates of need from GATS challenge. The Health Act did not exist in 1994 when SA made its GATS commitments covering health services. Consequently, neither the legislation in general, nor the certificates of need in particular, are protected from GATS challenge.

OTHER GATS ARTICLE XVI.2 ISSUES

There are other potential conflicts between certificates of need and GATS Article XVI.2.

The Health Act gives the Director-General of the national Department of Health, 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 certificate of need 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 specialised, 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.’

These are not merely technical inconsistencies. A foreign-owned medical services provider could defeat the redistributive purpose of South Africa’s health legislation by establishing a clinic in an already well-served neighbourhood or market niche, or by hiring doctors, nurses and other medical personnel away from higher-priority regions or health services. South African authorities, at all levels, would find it difficult 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 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”.¹⁵ The national treatment rule applies to the health services covered by South Africa’s specific commitments, creating a variety of regulatory issues and problems.

LOCAL CONTROL AND DECISION MAKING

In most countries, there is a strong tradition of local accountability and control in health services delivery. Such policies cut against the grain of national treatment. 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, thereby violating 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 WTO Services secretariat identified “technology transfer requirements, e.g. skilled foreign employees required to provide training to locals” as “some of the most common forms of national treatment restrictions”.¹⁶ There are no limitations protecting such non-conforming measures in South Africa’s schedule. This means that if a South African government negotiated with a foreign health service provider, conditioning its entry into the market on a commitment to transfer health technology or to train locals, enforcing such commitments could be contested as GATS-inconsistent.

SUBSIDIES

Most trade treaties, including the GATT and the North American Free Trade Agreement (NAFTA), exclude subsidies from the national treatment obligation.¹⁷ The GATS national treatment rule, however, applies fully to subsidies. This means that, in the covered health sectors, government subsidies, preferential loans, or other forms of financial support available exclusively to South African citizens, service suppliers, or community-owned health entities are exposed to GATS challenge.

BLACK ECONOMIC EMPOWERMENT

Black Economic Empowerment (BEE) is an affirmative action programme identified by the government as a major vehicle for addressing the economic injustices of apartheid.¹⁷ The BEE Act is applicable to all sectors of the South African economy, including health. On July 11, 2005 the government unveiled a draft BEE 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 2014.¹¹

j The GATT 1994 (Article III, 8(b)) and the NAFTA (NAFTA Article 301.1) rules on goods exempt subsidies from national treatment. Furthermore, 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).

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. BEE policies also run foul of GATS Article XVI. The requirement that 26% of a service investment be owned by black South Africans is effectively a limit of 74% on foreign ownership.

CONCLUSIONS AND RECOMMENDATIONS

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 arguably illegitimate, treaty commitments made by apartheid-era negotiators, or it can implement the Health Act and related policies aimed to achieve a more equitable health care system. The existing inequities within the health care system call for 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.

To date, the government has not brought forward regulations to bring the certificates of need into effect. As already noted, the certificates are a central, albeit controversial, feature of the Health Act. Hopefully, the prospect of international trade treaty litigation is not already a factor in the government’s foot-dragging on this matter.

In any event, failure to resolve this trade treaty issue promptly could enable foreign 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.

THE 'WAIT-AND-SEE' APPROACH

One option is for SA to implement the National Health Act as planned, and deal with any potential GATS issues as they arise. For diplomatic reasons, many governments may hesitate to bring such a challenge to the WTO dispute settlement system, fearing the international controversy that would likely result.

There are, however, serious pitfalls with this wait-and-see approach. Diplomatic concerns did not prevent the US government from championing the cause of global drug companies in their 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. The US 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 SA and abroad forced the global pharmaceutical manufacturers to withdraw their legal challenge to the legislation and for the US government to downplay its threat to bring trade action against South Africa.

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 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. 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.

The 'wait-and-see' approach therefore is unlikely to be effective. Due to the stark inconsistency between the Health Act and the GATS, disputes can be expected eventually. Losing such a case would expose SA to the threat of trade sanctions targeted against the country's key exports.

WITHDRAW SOUTH AFRICA'S GATS HEALTH COMMITMENTS

A second, more promising, option is for SA to withdraw its 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.^k SA would have to increase GATS coverage in other sectors to compensate affected WTO member governments for their service suppliers' lost 'market access' in health services.

Withdrawing the GATS commitments would remove the threat to the Health Act and other health measures. The obvious drawback, however, is that SA 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 Health Act and related health policies. If SA decides to pursue this option, the sooner it initiates the process the better. Awaiting the conclusion of the Doha Round, where SA faces strong pressure to pledge additional GATS commitments, would weaken its ability to negotiate reasonable compensation. The current suspension of the Doha Round negotiations therefore provides an important opportunity to begin the process of withdrawing the health services commitments.

^k GATS Article XXI allows countries to modify or withdraw a specific commitment after three years from the time the initial commitment is made. World Trade Organization, General Agreement on Trade in Services, Article XXI, (Modification of Schedules) in The Results of the Uruguay Round: The Legal Texts, Geneva, 1995.



CONFRONTING THE INCOHERENCE BETWEEN THE GATS AND HEALTH POLICY

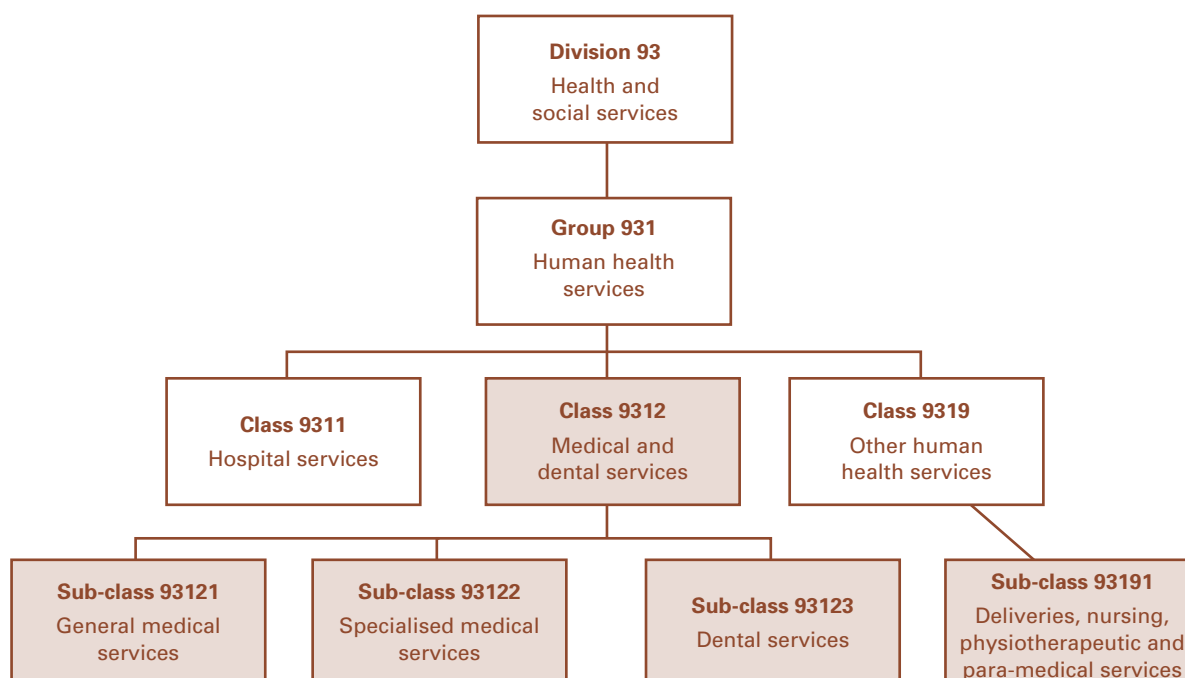
A third, more ambitious approach would begin with the withdrawal of the GATS commitments. But this would be accompanied by the South African government joining with – or even leading – like-minded governments and citizen movements to tackle the GATS threats to progressive health policies.

South Africa's dilemma provides a concrete example of the risks of making 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 powerfully illustrates why the GATS and similar trade treaties need to be fundamentally changed to eliminate the incompatibility between their commercializing imperatives and policies to realise health as a human right for all.

The serious conflicts between the Health Act and the GATS also underscore the repeated call from many developing countries for a thorough assessment of the impacts of existing GATS commitments before negotiations to broaden and deepen GATS coverage are concluded. There should now be a thorough assessment of the treaty's defects from a health policy and public interest perspective leading to 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 could then be viewed as a necessary first step towards the vital goal of creating more democratic international governance frameworks for human and social development.

FIGURE 1:
Health services covered by South Africa's GATS commitments



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