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Workshop on Equity in health issues

The General Agreement on Trade In Services (GATS) and Public Health

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Introduction and Historic Background of the GATS and Public Health

Basic services could be described as those services that one never thinks of until one is deprived of them. Health care is one such basic service that we always take for granted until we are sick and more when we are sick and we cannot get the service because we can not afford the service or there are other reasons that hinder us from obtaining the service. Traditionally, all basic services have fallen under the provision of governmental authority with the government holding the monopoly of the provision of such services. However, with the arrival of economic reforms, user fees were introduced and the private sector wasted no time in identifying a market and thus commodifying the basic services. The basic services include health care, water supply, energy supply, education, transport, etc. In this presentation, we will limit our scope of discussion to public health services and other health-related services.

Economic reforms such as Structural Adjustment Programmes (SAPs) have come and gone, and we are still feeling their impact on our economies and on our day to day lives. Even though the standards and regularity of the provision of public health services have gone down, the government is still active in this domain and is still *robbing the private sector of some of its profits.* It is in this light that the General Agreement of Trade in Services came into being.

The GATS found its way into the World Trade Organisation (WTO) through intense lobbying by the US Coalition of Services Industries (USCSI). The USCSI was created in the mid-70s when the American financial companies were faced with enormous difficulties in penetrating the heavily regulated South-East Asian market. They found the inclusion of trade in services in the General Agreement on Tariffs and Trade (GATT) as the only able tool to make a break into these markets. The USCSI lobbied US private sector and they achieved their goal at the conclusion of the Uruguay Round in 1994 and the GATS became operational on 1st January 1995.

What is GATS?

The GATS lays down the basic rules to conduct international trade in services and aims to promote international trade in services, and to remove barriers to such trade. The GATS applies to all services ranging from transport to health and education, to banking and telecommunications. It operates through four modes of supply namely, cross-border trade, consumption abroad, commercial presence and movement of natural persons. At the launch of the GATS, developing countries including Zimbabwe found the Agreement, through its Article IV, development friendly; and through its Article XIX, sympathetic and accommodating in allowing the liberalisation process to take place with due respect for national policy objectives. Other positive aspects of the GATS Article XIX include: provision for appropriate *flexibility* for individual developing country Members; provision of liberalising fewer types of transactions and progressively extending market access in line with their development situation; allowing them to attach market access conditions when making their markets available to foreign service suppliers. However, in real practice, the flexibilities of these articles are undermined when it comes to real negotiations. Developing countries do face unbelievable amount of political and economic pressure to liberalise even some sectors that they would not have dreamt of committing. This is how a rule-based institution like the WTO operates.

GATS and Public health

The GATS agenda is driven by transnational corporations (TNCs). This explains the motive behind trade liberalization. **Profit-making.** The flexibilities that could promote development through the GATS are being side-lined with promotion of foreign direct investment and profiteering taking precedence. Human rights are under threat. There is tremendous pressure on our governments to make commitments in basic services sectors like health and health-related services such as water supply, education, electricity supply. The first article of the GATS excludes such services from the scope of the agreement. However, the same article goes on to define such a service as one *"which is supplied neither on a commercial basis, nor in competition with one or more service suppliers."* In most countries, including Zimbabwe, public provision of services like health and education coexist with private sector provision. This means that public health services do fall under the GATS. The Health Sector under the GATS is meant to cover only private health services, but the qualifying adjectives "commercial" and "competition" directly imply that public health services are also included and should therefore respect all rules of the GATS.

Fortunately (but not for long), Zimbabwe has not yet made any commitments in public health, water supply and education. This means that the provision of such services are still out of reach of the complete liberalization threat. However this is not going to last for long! The provision of these very services under governmental authority are deplorable. Public hospitals are run down, fees are hicking, health professionals are leaving the country, there are regular water cuts, just to mention a few of the many of our day to day problems. Even though Zimbabwe has not yet received any requests in these sectors at the moment, a closer look at the situation does prompt some developing countries to do so. Lack of immediate solutions could in turn make the government make hurried commitments in these sectors.

Furthermore, if we bring the picture closer home, we can refer to the recent proposal from the Harare City Council. The town clerk of Harare recently submitted his proposal for the improvement of public services delivery for city. He is proposing that the Harare City Council departments be transformed into twelve autonomous business units. Some of these units include Harare Health which will be in charge of primary health delivery, Harare Water which will cater for water and sewage treatment; Harare Environment which will take over the general cleaning of municipal areas and refuse collection and disposal. The main objective of these units is to come up with efficiently managed public services which will operate in the private sector sense: *efficient and self sustainable.* The long-term objective is to come up with private-public partnerships in the management and provision of these public services. The units will be self-funding, receiving no annual grants from the city and providing billable services direct to individual households. This means that they will generate their own money to run the unit as well as the services and will not depend on the general government budget allocation.

This idea has been borrowed from the Johannesburg Unicity structure which gives it some authenticity and weight. Also, when we look at the current prevailing economic situation, where the government budget is proving inadequate and the government hospitals run down, public health services deplorable, etc., this idea looks very sound and reasonable. However taking a closer look at this proposal, parliamentarians should raise some of the following concerns: If the current system is failing to raise adequate funds to manage and provide good primary public health services, how will the business-managed unit do it to raise adequate funds given the fact that it will not even draw from the government budget? If the current user fees being collected from the public health institutions are not adequate to maintain and provide the required services, how will they do it under the new proposed system? **The natural response is that all fees will**

go up and not only by small margins. This proposed plan will *probably* solve the major problems of inefficiency and unaccountability, but it will generate larger problems. The primary health care services will be out of reach for many. It will be out of reach for the people it is meant to serve. In such an environment, there will be no distinction between public health services and private health services. This will make the predators, the transnational corporations (TNCs) smile, because, Zimbabwe would have created an **enabling environment** for them at no cost. This will be an open call to privatization, complete liberalization and operationalisation of the Investment Agreement that is already hidden in the GATS.

Health-related Services and FDIs through the GATS

Mode 3 of the GATS allows a foreign service supplier to establish, operate or expand commercial presence in another Member's territory, such as a branch, agency, or wholly-owned subsidiary. Commercial presence is the mode of supply most wanted by developed countries. Developed countries argue that, through this mode of supply, they will bring in capital, technology and know-how and hence enhance development of developing countries opening up their markets to this mode of supply. In all their proposals, developed countries are, therefore, asking for minimal restrictions to mode 3. They are targeting strategic sectors of the African economies – sectors of public services – in particular health, water supply and electricity supply. So, what is the most likely response of our governments to such kind of moves?

After the disasterous structural adjustment programmes (SAPs), our governments have reached a point where they can no longer sufficiently provide these services that traditionally fell under their authority. To remove this burden off their shoulders, they have embarked on a fast track privatisation programme. Privatisation means changing of ownership from public hands into the private hands. Private hands, be they foreign or indigenous, they are driven by the same motive. **Profit-making if not profiteering**. Their pricing strategies are the same. Affordable at first and sky-rocketing as they go. The services will eventually be out of reach for many. Seeing the dilemma that the African governments are in in terms of managing public services, TNCs see an opportunity to make money. They pressurise their governments (developed country governments) to use the GATS to take advantage of the situation and multilateralise the liberalisation process. Their governments are therefore making requests to developing countries to make commitments in the very sectors that are in shambles. *The pressure has even intensified given the collapse of Cancun.*

Our governments are made to believe that foreign direct investment through commercial presence is the only way that they can save their people from the water shortage problems, badly equipped hospitals, inefficient collection and disposal of refuse. Since these services are commodities, they do present an opportunity for investment for capable service suppliers. As investments, they are open to all members of the WTO through the **Most Favoured Nation clause**. And through the GATS, all investors have a right to equal treatment through the **National Treatment clause.** This means that they have to give same treatment to the foreign companies as well as local companies. In such a case, it is obviously the foreign companies that benefit because they have ready capital to invest. This means that they will bring immediate remedies and save the faces of our governments.

However, what our governments usually fail to put to question is the commitment behind these foreign investors. For how long are they going to be around to serve the basic needs of their (the governments) people? This question is not usually posed, because we always want to save crisis situations and avoid long-term challenges. But the real response to the question is that, **foreign companies will stay as long as they make profits.** Foreign owned companies will not tolerate

customers who do not pay their bills on time. Foreign companies will not cater for low-income earners who might give them problems in the long run. They would rather leave them out completely. This is already happening in financial institutions in Zimbabwe (e.g. old Mutual and other local banks). The Medical Aid institutions are no exception. Poor segments of the population are being dropped off and being cut off from specialized health services they need most, because they cannot afford the exorbitant premiums. It is therefore imperative for the parliamentarians to understand the dynamics of the GATS and its implications on the provision of public health in particular.

Why is the GATS particularly Important for Parliamentarians?

It is important mostly because the power of the governments to determine domestic policy is under threat through the GATS. The GATS is intrusive on domestic regulation. Through the GATS Article VI.4, the flexibility of policy makers to achieve legitimate policy objectives for the good of their people might be constrained. Further liberalisation in the GATS will be meaningful if the governments do not lose their ability to regulate economic activity and to provide basic, affordable and accessible services to all their people. Advocates of the GATS argue that the GATS Article VI.4 on Domestic Regulation permits the governments to protect their basic services. However, this Article on Domestic Regulation takes a minimalist view on kinds of regulations that should cover services. This article states that disciplines relating to qualifications, procedures, licensing and technical standards should be "*no more burdensome than necessary to ensure the quality of the service."* However, *"the quality of the service"* does not address the critical question of distribution of services. This leaves populations in poverty extremely vulnerable to neglect as key public services, such as garbage collection, are privatised. Nor is there any criteria for determining *"more burdensome than necessary."* The ambiguities leave a given country's regulations to ensure universal and affordable health care, for example, open to the WTO dispute settlement mechanisms. **What this Article actually mandates is that, government regulation is permitted as long as it does not constitute an unnecessary barrier to trade.**

In addition to all this, the most important reason why Parliamentarians should be concerned about the GATS is the **'irreversibility' nature of the GATS commitments.** The GATS commitments are 'irreversible', regardless of changes of government. The term *irreversible* is in quotes because there are some articles of the GATS that allow for reversibility of commitments, but their implementation is problematic to most developing countries. The GATS allows Members to renegotiate their commitments against compensation (Article XXI), ignore them for health and other public policy reasons (Article XIV) or security concerns (Article XVI *bis*), and introduce restrictions to protect the Balance of Payments (Article XII). While these provisions seem to give some flexibility on commitments of governments, they remain impossible to implement because, developing country governments, Zimbabwe included, do not have the financial capacity to meet the compensation that might be required. Furthermore, renegotiating commitments might mean putting under threat some of the unopened sectors. The most difficult thing for the developing countries will be for them to prove that the negative impact (prompting them to reverse their commitments) is solely due to the liberalisation of the particular service sectors. The losing country can take the country seeking to reverse their commitments, to the Dispute Settlement Body. This will make it unaffordable for developing countries like Zimbabwe. So, in the end, developing countries would rather keep their commitments as they are. So, even though the current economic situation is deplorable, the government should not make a mistake of making commitments in health, water supply or education under the GATS. No only because f the

irreversibility nature of the commits, but more because it I the government's responsibility to cater for such services.

What Parliamentarians can Do/ Way Forward

We will borrow our way forward by reconfirming the resolutions of a meeting of representatives of parliamentary committees on health, health professionals, civil society and co-operating organisations from Kenya, Malawi, South Africa, Tanzania, Zambia, Zimbabwe and SADC, hosted by EQUINET and GEGA in co-operation with the SADC Parliamentary Forum - Johannesburg in August 2003. The meeting confirmed the policy commitment in the region to equity in health and acknowledged the ongoing work towards implementing health equity policies. The meeting urged that greater effort be made to deal with differences in health status and access to health care that are unnecessary, avoidable and unfair.

The meeting noted that achieving health equity in the region demands that countries address economic, governance, food security, HIV/AIDS and other major challenges to health and for countries to create and protect sustainable, equitable and participatory health systems that are provided with adequate material and human resources. Achieving health equity calls for countries to allocate more resources towards those with greater health needs, and depends on the extent to which different groups of people have the opportunity for participation and the power to direct resources towards their health needs. To this end, the meeting agreed that parliamentary committees on health promote health equity in the budget process.

As regards to GATS, the meeting resolved that:

- Countries protect their government authority in all trade agreements to safeguard public health and regulate services in the interests of public health;
- Government trade negotiators consult health ministries, parliamentary health committees and civil society on positions to be taken to trade negotiations for their public health implications;
- Governments not make any commitments under the General Agreement on Trade in Services (GATS) in health or health related services that compromise their right to regulate according to national policy objectives;
- Countries conduct a comprehensive 'health check' on GATS commitments made or proposed so far, with the active involvement of health ministries, parliamentary health committees and civil society;
- Countries call for a change to GATS rules that restrict them from retracting in commitments already made under GATS.

Furthermore:

- Parliamentarians should remember that they are the mouth piece of the people they represent. They should therefore give top priority to the concerns of their constituencies. This means that they should have some interest in the issues under GATS negotiations. They should then inform their constituencies of the implications of the GATS and discuss with them about possible options and recommendations. They should then take these concerns to the Parliament and ask that some of these GATS negotiations, (especially commitments in public services be subject to parliamentary debate before approval). This will enhance making informed decisions at all levels.
- Parliamentarians should advocate for regional integration first before integration into the multilateral system.

- Parliamentarians should also advocate for reinforcement of bargaining power of their governments by negotiating as a region at international / multilateral level. This tactic did move mountains in Cancun but is already under threat e.g. under Cotonou negotiations.
- Parliamentarians should also seek advice, consult and work together with parliamentarians from other regions of the continent.

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