Protecting public health and equitable health services in the services negotiations of the EU-ESA Economic Partnership Agreements

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Executive summary

The African-Caribbean and Pacific (ACP) group of countries has been negotiating new trade relations with the European Union (EU). The resulting set of agreements will be dubbed Economic Partnership Agreements (EPAs). In December 2007 the East and Southern Africa (ESA) group of countries signed an interim EPA with the EU and agreed to negotiate outstanding issues over the course of 2008 so that by December 2008 a full EPA is signed. Part of these negotiations includes the liberalisation of trade in services. The Southern and Eastern African Trade Information and Negotiations Institute (SEATINI) and the Training and Research Support Centre (TARSC) under the umbrella of the Regional Network for Equity in Health in east and southern Africa (EQUINET) are carrying out work on the health and trade theme. One area of concern to these stakeholders was a review of the health and health care issues in the EPAs.

This paper aims to provide a detailed analysis of the options for protecting universal comprehensive and equitable health services within the framework of the EU-ESA EPA and other EPAs in the region through the services negotiations. The study has used a number of sources of evidence, including primary and secondary data. The major limitation on the sources of evidence is the lack of transparency and access to official documentation on the negotiations. This makes informed analysis difficult, and leaves a lot of data being ascribed to 'sources within the ESA-EU parties'.

The paper notes a number of commitments that the ESA-EU countries have already made in relation to public health. These commitments are evident in bilateral (Cotonou Agreement) and multilateral agreements (such as the various human rights covenants under the United Nations (UN) system). Added to these are commitments made at various ESA national levels as contained in the constitutions of these countries. The study assesses the EPA negotiations and identifies areas where there are inconsistencies between the content of the negotiations and these existing commitments made to public health.

The implications of the General Agreement on Trade in Services (GATS) are also analysed. It is suggested that ESA countries exclude the health sector from the services liberalised in the EPA negotiations. Most ESA countries have not made any commitments in the health sector under the GATS and it is still possible to maintain this position with respect to the EPA process.

As a guiding principle, it is suggested that ESA countries use human rights as a basis for the protection of health and health care services in the EPA. This is argued given the existence of clear international, regional and national commitments that recognise health as a human right, as presented in this paper. Both ESA and EU countries are signatory to these international commitments and the EPA must be compliant with them. There are specific protections for public health and health care services within them and these need to be respected. Furthermore, ESA countries have such protections in their constitutions and laws that need to be noted in any trade negotiations.

ESA countries should ensure that there is a clause protecting public health and recognizing state obligations to protect universal and equitable access to health services through the public sector in the EPA content. This can be achieved by inserting a clause in the EPA that not only excludes the liberalisation of the health sector, but that also

recognizes the priority for protection of public health as a guiding principle, as in the EU-Southern African Development Community's (SADC) Interim Economic Partnership Agreement (IEPA), and commits the parties to allowing government authorities and availing specific resources to the public health sectors of ESA countries. This should be part of the development dimension of the EPA. This protection should include a firm commitment by the EU to avail funds to ESA countries, to counter the effect of revenue losses due to the liberalisation of trade in goods.

The demand for public sector leadership in health services in poor and vulnerable communities in ESA raises a number of issues that need to be integrated within the services negotiations. The policy demand for equity in health calls for implementation of article 25 of the Cotonou Agreement, committing the ACP-EU parties to make available adequate funds for:

- improving health systems and food security;
- integrating population issues into development strategies to improve reproductive health and primary health care;
- promoting the fight against HIV/AIDS; and
- increasing the security of and access to safe water and adequate sanitation.

It is necessary to place the health sector as part of the development chapter of the comprehensive EPA: implementation of article 34 of the Cotonou Agreement. This entails negotiating technical and development finance assistance targeted at the health sector, as part of the sustainable development cooperation envisaged under article 34 of the Cotonou Agreement.

Investment rules need to be negotiated to channel resources into the ESA health sector according to the identified needs of the ESA countries, including in regulating their private for profit health sectors to provide for an affordable basic level of health care benefits complementary to the public health sector.

1. Introduction

The African-Caribbean and Pacific (ACP) group of countries is currently in the process of negotiating new trade relations with the European Union (EU), referred to as economic partnership agreements (EPAs). These EPAs were meant to have been signed in December 2007 but this failed to happen due to a number of concerns that were raised by the various ACP groupings (primarily on the development impact of the agreements). Instead, interim EPAs were signed by most of the parties, which address trade in goods only, and exclude services. The interim EPAs also contained clauses for future negotiations of the outstanding issues, such as trade in services and rules on investment-related matters, which were supposed to have been concluded by the end of 2008, but appear to remain unresolved at the time of publishing this paper (March 2009).

This paper was commissioned by the Regional Network for Equity in Health in east and southern Africa (EQUINET), through the Southern and Eastern African Trade Information and Negotiations Institute (SEATINI) and the Training and Research Support Centre (TARSC), who became concerned that health rights and systems will be eroded by signing EPAs unless they include key clauses protecting health. East and southern African (ESA) negotiators and other stakeholders requested a review of the health and health care issues in the EPAs. The paper is intended to support the negotiation of health rights in the EPAs, particularly in the services negotiations, and falls under EQUINET's health and trade theme area. Negotiations in areas most relevant to health issues such as services and intellectual property rights (IPRs) will be taking place in 2009.

The paper aims to provide a detailed analysis of the options for protecting universal comprehensive and equitable health services within the framework of the EPAs between countries in east and southern Africa and the European Community (called ESA-EC EPAs) and other EPAs in the region through the services negotiations. We used a number of sources of evidence, including primary and secondary data. The report in draft form was also discussed at a meeting of state, civil society and academic officials from trade and health sectors and parliamentarians from Uganda, Kenya and Zimbabwe, and their comments were integrated into the final document.

Global trends in trade in health services indicate that this sector is growing and profitable. Chanda (2002) notes that, in Organisation for Economic Co-operation and Development (OECD) countries, the health sector generates US$3 trillion per year. While not specified, it is understood that this covers both private and public sectors. Furthermore, some developing countries have become important destinations for patients from rich countries seeking specialised treatment that is cheaper abroad than at home. Some countries, like India, attract patients from the United States of America (USA), Bangladesh, Eastern Mediterranean, Nepal, Sri Lanka and the United Kingdom, Another example is Cuba. Between 1995 and 1996, more than 25,000 foreign patients went to Cuba for treatment, generating US$25 million in sales of health services by providing services to patients from Latin America, the Caribbean, Europe and Russia. (Chanda does not, however, indicate whether this revenue includes health services provided to Latin American countries as part of the trade arrangements between Cuba and those countries, for example, when Cuba receives oil supplies in exchange for health services.) This new trend in global health has led to some developing countries diversifying their health sector in order to attract patients from abroad. Cuba, for example, has diversified its health sector by creating specialised hospitals, focusing on

the treatment of certain skin diseases that are incurable in other countries, and on the development of new procedures and drugs, such as those for pigmentary retinopathy or vitiligo. Specialty hospitals in India get surgery cases referred from the USA and other countries.

The above trends have not reached sub-Saharan Africa yet. This is possibly because the value of the health services sector in Africa is very difficult to quantify. In most African countries, the private for-profit health services market is underdeveloped. A recent study by McKinsey (2008), a consultancy, suggests that sub-Sahara Africa's private health sector is already large and diverse and that improved economic growth across much of the region could translate into $20 billion of additional investment in the region's private sector health care infrastructure in the coming decade. The study argues that there are investment opportunities in the private health care sector in sub-Saharan Africa, and that these relate to health care provision, distribution and retailing of pharmaceuticals and equipment, life sciences, risk pooling and medical education. It recommends that sub-Saharan Africa governments should modify local regulations that impede the development of the private health sector such as trade barriers that limit access to health supplies.

The McKinesy report gives a misleading sense of the size and role of the private for profit health sector in sub-Saharan Africa, because it is based on a definition of the private sector that includes all health services not provided by the government. This includes not just for-profit organisations, but also non-profit organisations such as private donors, non-governmental organisations, faith-based organisations, social enterprises, as well as traditional healers. The study also does little to refute the fact that the majority of Africans cannot afford the private for-profit health facilities and that private not-for profit health care providers (such as faith-based organisations) and the public health sector still remain central to the region's health care systems (EQUINET and SEATINI, 2007). In our study, we intend to correct this error by defining the private sector and its involvement more carefully in our analysis of trade issues.

2. Methods

The study used a number of sources of evidence, including primary and secondary data.

The major limitation of the sources of evidence was the lack of transparency with respect to the ESA-EC negotiating documentation. It is almost impossible to acquire any official documentation of the numerous technical or political level meetings covering the services negotiations. The secrecy with which the negotiations are being conducted makes any informed analysis difficult, and much data had to be ascribed to 'sources' within the ESA-EC parties.

This also raises questions of transparency, accountability and civil society involvement (i.e., the process is exclusive, not inclusive of all stakeholders). Sources of evidence include internet, web search, EQUINET, SEATINI, WHO, government reports, civil society, and published multilateral agency reports.

3. EU and ESA country commitments affecting the negotiations

The current negotiations between the ESA and EU states are taking place against a background of numerous health sector commitments made by these countries. The EPA negotiations have the potential of enhancing or belittling these commitments. The negotiating positions open to the countries are better served by an acknowledgment of the historical and recent commitments made by both set of countries with respect to health and health care. This section of the paper identifies and discusses a number of commitments made by the ESA and EU countries. It places these commitments within the current negotiations for a full ESA-EU EPA, specifically with regard to services.

3.1 The Cotonou Agreement, June 2000

The Cotonou Agreement, signed in June 2000, is the basis for the new trade and development co-operation relationships between the African-Caribbean and Pacific (ACP) states and the EU. It covers a number of issues, of which the provision for EPAs is only one. The EPAs are covered under Part 3 of the agreement, particularly articles 36 and 37, which provide for the negotiation of the EPAs. The trade aspects of the agreement have a direct link with the health concerns arising out of the EPA negotiations. Implicit and explicit in the agreement is a commitment by the EU and ACP states to observe the international agreements that have a direct and indirect link with the provision of health services as a human right. For example, the preamble to the Agreement refers to a number of earlier rights-based agreements, namely the Charter of the United Nations, the Universal Declaration of Human Rights, the Vienna Conference on Human Rights, the International Covenants on Civil and Political Rights and on Economic, Social and Cultural Rights, the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination against Women, the International Convention on the Elimination of all Forms of Racial Discrimination, the Third Geneva Convention and other instruments of international humanitarian law (see *Table 1*). Also considered important in the Agreement are the Convention for the Protection of Human Rights and Fundamental Freedoms of the Council of Europe and the African Charter on Human and People's Rights.

Although the substantive body of the Cotonou Agreement does not make any specific reference to these international covenants and their health-related commitments, it does refer to international development agreements:

> *Cooperation shall refer to the conclusions of United Nations conferences and to the objectives, targets and action programmes agreed at international level and to their follow up as a basis for development principles. Cooperation shall also refer to the international development cooperation targets and shall pay particular attention to putting in place qualitative and quantitative indicators of progress* (ibid, article 19.2)*.*

Although not specifically mentioned, it is reasonable to read this provision as recognising the UN Millennium Development Goals (MDGs), which have crucial 'qualitative and quantitative indicators of progress' on the provision of health care and health-related services in developing countries. In addition, it is not necessary for the Cotonou Agreement to make explicit reference to the international conventions since the EU and ESA countries have independently ratified them in separate processes.

Table 1 summarises the international health-related agreements referred to in the Cotonou Agreement.

Table 1: International health-related agreements recognised in the Cotonou Agreement

International health-related agreements	Commitments to health
Charter of the United Nations (1945)	Article 55 committed member states to promote higher standards of living, full employment, and conditions of economic and social progress and development. Further commitments were made to promote solutions for international economic, social, health and related problems. The Charter is the agreement on which the World Health Organisation (WHO) is based.
Universal Declaration of Human Rights (1948)	Article 25 recognises that everyone has the right to a standard of living adequate for their health and well being, including food, clothing, housing, medical care, necessary social services, the right to security in the event of unemployment, sickness, disability, loss of a spouse, old age or other lack of livelihood in circumstances beyond their control. There is a special provision acknowledging that mothers and children should be entitled to special care and assistance.
Convention for the Protection of Human Rights and Fundamental Freedoms of the Council of Europe (1950)	The Convention refers to the importance of the Universal Declaration of Human Rights but does not specifically refer to health.
European Social Charter (1961)	The Charter guarantees social and economic rights, and recognises the right of everyone to benefit from any measures enabling the enjoyment of the highest possible standard of health attainable.
Covenant on Economic, Social and Cultural Rights (1966)	Article 12 commits the states that signed this agreement to recognise the right of everyone to enjoy the highest attainable standard of physical and mental health. States should take the steps needed to: ・ reduce still-birth and infant mortality rates and promote the healthy development of all children; ・ improve all aspects of environmental and industrial hygiene; ・ prevent, treat and control epidemic, endemic, occupational and other diseases; ・ create conditions to ensure that all who need medical attention in the event of sickness will receive it.
African Charter on Human and People's Rights (1986)	Article 16 gives every individual the right to enjoy the best attainable state of physical and mental health and also obliges states to take necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.
Convention on the Elimination of all Forms of Discrimination against Women (1979)	The Convention creates obligations for states with respect to the health of women, in general, and women living in rural areas, in particular, and provides under articles 12 and 14 that: ・ State parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure equal access to health care services, including those related to family planning. ・ State parties shall ensure women receive appropriate services in connection with pregnancy, confinement and the post-natal period. They should grant free services where necessary, as well as ensure adequate nutrition during pregnancy and lactation. The Convention enjoins states to ensure that rural women have access to adequate health care facilities, including information, counselling and services in family planning.

Convention on the Rights of the Child (1990)	Article 23 recognises the rights of disabled children to have access to health care services before article 24 goes on to outline the obligations of those states that signed this agreement, with respect to the health of children: · State parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. They shall strive to ensure that no children are deprived of their right of access to such health care services. · State parties shall pursue full implementation of this right and, in particular, shall take appropriate measures: – to diminish infant and child mortality; – to ensure the provision of necessary medical assistance and health care to all children, with emphasis on the development of primary health care; – to combat disease and malnutrition, including within the framework of primary health care, through the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution; – to ensure appropriate pre-natal and post-natal health care for mothers; – to ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents; and – to develop preventive health care, guidance for parents and family planning education and services. · State parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children. · State parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realisation of the right recognised in the present article. In this regard, particular account shall be taken of the needs of developing countries.

Sources: UN, 1945, 1948, 1966, 1979; Council of Europe, 1950, 1961; Organisation of African Union (OAU), 1986.

3.2 Health-related commitments made by ESA states

The ESA countries have also made numerous health systems commitments in the context of agreements and programmes at regional, continental and international levels. Regional commitments are relevant to the SADC and Common Market of east and southern Africa (COMESA) contexts since some ESA members are members of both regional organisations. Their commitments are summarised in *Table 2*.

The ESA group has also committed itself to the main international human rights instruments that have direct and indirect relevance to the provision of health care. (The contents of these international human rights mechanisms are summarised in *Table 1* shown earlier.) *Table 3* below shows other international human rights treaties that these ESA countries have ratified and committed themselves to (EQUINET et al, 2008).

As summarised in *Tables 1 and 2*, these conventions create a set of obligations to be discharged by the state parties for the benefit of their citizens' health. It is important to note that these conventions have been around for decades, and many of the ESA states have ratified them, but the actual delivery on the conventions has not been forthcoming. Consequently, ESA governments must be very careful to avoiding further compromising their poor health delivery systems in the course of the EPA negotiations.

Table 2: Regional health-related commitments made by ESA states

Agreement/Programme	Health-related commitments
COMESA Treaty (1993)	Articles 110-111 of the Treaty commits the ESA countries that are members of COMESA to co-operate for the development of an effective health delivery system by: ・ facilitating of movement of pharmaceuticals within the common market; ・ training staff to deliver effective health care; and ・ designating national hospitals as common market referral hospitals.
SADC Protocol on Health (1999)	The protocol applies to Zambia, Zimbabwe, Mauritius and Malawi in the ESA context and aims to: ・ attain an acceptable standard of health for all citizens; ・ commit government to the primary health care approach; ・ ensure equitable and broad participation for mutual benefit in regional co-operation in health; and ・ harmonise the health sector.
Abuja Declaration on Roll Back Malaria in Africa (2000)	The Abuja Declaration set the following goals for the year 2005: ・ At least 60% of those suffering from malaria should have prompt access to, and be able to correctly use, affordable and appropriate treatment within 24 hours of the onset of symptoms. ・ At least 60% of those at risk from malaria, particularly children under five years of age and pregnant women, should benefit from the most suitable combination of personal and community protective measures, such as insecticide-treated mosquito nets and other interventions that are accessible and affordable to prevent infection and suffering. ・ At least 60% of all pregnant women who are at risk of malaria, especially those in their first pregnancy, have access to chemoprophylaxis or presumptive intermittent treatment.
Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (2001)	The Abuja Declaration set the following goals: ・ Allocate at least 15% of annual budget to the improvement of the health sector. ・ Avail the necessary resources to improve the comprehensive multi-sectoral response for the fight against HIV/AIDS, TB and other related infectious diseases.
New Partnership for Africa's Development (2001)	・ New Partnership for Africa's Development's (NEPAD) aims are to: ・ ensure the necessary support capacity for the sustainable development of an effective health care delivery system; ・ strengthen Africa's participation in processes aimed at procuring affordable drugs; and ・ encourage African countries to give higher priority to health in their own budgets and to phase in such increases in expenditure to a level to be mutually determined.

Sources: OAU (2000, 2001a, 2001b), COMESA (1993), SADC (1999).

Table 3: International human rights treaties that have been ratified by ESA countries, 2004

Countries	Treaties and years of ratification											
	CESCR	CCPR	CCPR-OP1	CCPR-OP2	CERD	CEDAW	CEDAW-OP	CAT	CRC	CRC-OP-AC	CRC-OP-SC	CMW
Burundi	1990	1990	N/A	N/A	1977	1992	2001	1993	1990	2001	N/A	N/A
Ethiopia	1993	1993	N/A	N/A	1976	1981	N/A	1994	1991	N/A	N/A	N/A
Eritrea	2001	2002	N/A	N/A	2001	1995	N/A		1994	N/A	N/A	N/A
Djibouti	2003	2003	2003	2003	N/A	1999	N/A	2002	1991	N/A	N/A	N/A
Kenya	1976	1976	N/A	N/A	2001	1984	N/A	1997	1990	2002	2000	N/A
Madagascar	1976	1976	1976	N/A	1969	1989	2000	2001	1991	2000	2000	N/A
Malawi	1994	1994	1996	N/A	1996	1987	2000	1997	1991	2000	2000	N/A
Mauritius	1976	1976	1976	N/A	1972	1984	2001	1993	1990	2001	2001	N/A
Rwanda	1976	1976	N/A	N/A	1975	1981	N/A	N/A	1991	2002	2002	N/A
Seychelles	1992	1992	1992	1995	1978	1992	N/A	1992	1990	2001	2001	2003
Sudan	1986	1986	N/A	N/A	1977	N/A	N/A	1986	1990	N/A	N/A	N/A
Uganda	1987	1995	1996	N/A	1980	1985	N/A	1987	1990	2002	2002	2003
Zambia	1984	1984	1984	N/A	1972	1985	1985	N/A	1998	1992	N/A	N/A
Zimbabwe	1991	1991	N/A	N/A	1991	1991	N/A	N/A	1990	N/A	N/A	N/A

KEY: N/A *– Not applicable (Did not ratify the treaty);* ***CESCR*** *– International Covenant on Economic, Social and Cultural Rights;* ***CCPR*** *– International Covenant on Civil and Political Rights;* ***CCPR-OP1*** *– Optional Protocol to the International Covenant on Civil and Political Rights;* ***CERD*** *– International Convention on the Elimination of All Forms of Racial Discrimination;* ***CEDAW*** *– Convention on the Elimination of All Forms of Discrimination against Women;* ***CEDAW-OP*** *– Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women;* ***CAT*** *– Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment;* ***CRC*** *– Convention on the Rights of the Child;* ***CRC-OP-AC*** *– Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict;* ***CRC-OP-SC*** *– Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography;* ***MWC*** *– International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families*

Source: Office of the United Nations High Commissioner for Human Rights, 2004.

Some ESA countries also provide guarantees for access to medical services within their legislation or constitution. Such guarantees are commitments that should be acknowledged in the context of trade negotiations as they are relevant to the level of flexibilities that governments have in such negotiations. There is a real possibility that some rights guaranteed by law may be taken away as part of a market access provision in trade agreements. Identifying such rights is the first step to be taken before creating negotiating positions. *Table 4* below identifies the relevant constitutional provisions in a sample of six countries from east and southern Africa. The countries were selected randomly to illustrate how their constitutions address the right to health.

Table 4: The right to health in the constitutions of selected ESA countries

Country	Provisions in the country's Constitution
Ethiopia	Article 41 states that: • Every Ethiopian citizen shall have the right to equal access to social services run with state funds. • The state shall allocate progressively increasing funds for the purposes of promoting people's access to health, education and other social services. • The state shall, within the limits permitted by the economic capability of the country, care for and rehabilitate the physically and mentally handicapped, the aged and orphans.
Madagascar	Article 19 stipulates that the state shall recognise every individual's right to the protection of their health, starting from conception.
Malawi	Article 13 (as read with article 14) states that the state is obliged to actively promote the welfare and development of Malawi by progressively and implementing policies and legislation aimed at achieving a number of goals, which include health: • to provide adequate health care, commensurate with the health needs of Malawian society and international standards of health care; • to manage the environment responsibly in order to provide a healthy living and working environment for the people of Malawi; and • to encourage and promote conditions conducive to the full development of healthy, productive and responsible members of society.
Rwanda	• The Constitution reaffirms adherence to the major human rights treaties. • Article 41 states that all citizens have the right and duties relating to health. The state has the duty of mobilising the population for activities aimed at promoting good health and to assist in the implementation of these activities.
Sudan	Article 13 stipulates that the state shall promote public health, encourage sports and protect the natural environment, its purity and its natural balance, as well as ensure safe, sustainable development for the benefit of all future generations.
Uganda	Articles XX and XXI stipulate that the state shall take all practical measures to ensure the provision of basic medical services to the population. It shall also take all practical measures to promote a good water management system at all levels.

Sources: Government of Ethiopia (1994), Government of Madagascar (1992), Government of Malawi (1995), Government of Rwanda (2003), Government of Sudan (1998), Government of Uganda (1995).

Table 4 shows that some ESA countries actually consider health as a constitutional issue. The issue is treated differently in each country; for example the Uganda situation has the health consideration mentioned in the preamble as opposed to the substantive body of the constitution. It is very difficult to enforce a preambular provision that is not backed up by mechanisms for implementation in the substantive body of a constitution. Furthermore, in some cases it is not clear whether there is a 'right to health' as such, in legal parlance, that is whether such 'right' is justiciable. The Malawian example is

clarified in article 14, which implies that the 'right to health' being one of the principles of national policy 'shall be directory in nature but courts shall be entitled to have regard to them in interpreting and applying any of the provisions' of the constitution. (For a more detailed treatment of the Malawian case, see Mabika and London, 2007.) The important point to note here is that although there are doubts on whether or not such 'rights' are actionable, the governments in question recognised the need to at least indicate the significance of health within their national constitutions, a fact that clearly gives right to the legitimate expectations of citizens that the state will act in the best interests of their health. This obviously includes situations where the state is negotiating trade agreements that may have an implication on these expectations.

A number of health and health-related rights are provided for in the constitutions identified in *Table 4* above. These range from equal access to social services, rehabilitation of the physically and mentally handicapped, adequate health care, good water management and basic medical services. It cannot be overemphasised that there are clear community or public interests and legitimate expectations with respect to the provision of medical services, and these cannot be simply ignored in the rush for a comprehensive EPA. ESA countries' negotiators need to be aware of the constitutional provisions addressing the right to health, and to ensure that the negotiations do not encroach on these constitutional rights. The failure to align the negotiations with constitutional obligations will expose ESA governments to future litigation, should citizens feel aggrieved that health-related rights have been infringed upon in the EPA framework.

4. Commitments to the health sector within the trade agreements

The trade agreements discussed in this paper – the Cotonou Agreement and the Interim EU-ESA Economic Partnership Agreement – make various references to the health sector. Let's look at these more closely.

4.1 The Cotonou Agreement

The Cotonou Agreement refers to health-related matters in its preamble. The substantive body of the Agreement attempts to give some tangible commitments to the preamble by providing for a number of health-related obligations on the part of the state parties to the Agreement.

Article 25 of the Agreement is a very important health-related provision within the context of this paper. It obliges the EU to support ACP states' efforts at developing general and sectoral policies and reforms that improve the coverage, quality of and access to basic social infrastructure and services and take account of local needs and specific demands of the most vulnerable and disadvantaged. The purpose of this cooperation is to reduce inequalities in access to these services. Article 25 requires special attention to be paid to ensuring adequate levels of public spending in the social sectors by:

- improving health systems and nutrition, eliminating hunger and malnutrition, and ensuring adequate food supply and security;
- integrating population issues into development strategies to improve reproductive health, primary health care, family planning and fighting against female genital mutilation;
- promoting the fight against HIV/AIDS; and

- increasing the security of household water and improving access to safe water and adequate sanitation.

Article 25 is a clear statement on the significance of the development of the social sector, which includes addressing inequalities in access to health care services. Article 31 is meant to be read with Article 25, as it makes provision for cooperation on gender-related issues. This provision obliges state parties to cooperate in order to improve the access of women to all resources required for the full exercise of their fundamental rights. More specifically, it is meant to create an appropriate framework to, for example, encourage the adoption of specific positive measures in favour of women, such as 'access to basic social services, especially to education and training, health care and family planning'.

Part 3 of the Agreement deals with economic and trade cooperation between ACP and EU states. Article 34 thereof provides that economic and trade cooperation shall have due regard for the ACP states' political choices and development priorities, thereby promoting their sustainable development and contributing to poverty eradication in the ACP countries. The language of the new trade relationship between the ACP-EU countries is based on the promise of the development benefits arising out of liberalisation. Sustainable development must be interpreted as including improvements in health delivery systems and institutions so, in the context of this paper, article 34 has important implications for the health sector within the EPA dimension. It is arguable that this provision should be read as a commitment to enhance the health delivery systems in the ACP states as part of a comprehensive EPA.

This point is further buttressed by article 41, in which the ACP-EU states underlined the growing importance of services in international trade and their major contribution to economic and social development. However, this provision does not purport to protect or promote specific ACP services providers or specific services sectors in the ACP states.

Competition policy addresses various issues such as monopolies, abuse of market dominance, unfair business practices and consumer protection. Breaking monopolies and conglomerates through the use of competition policy is one way of allowing new entrants into the market place. In other words, domestic upstarts (new firms without prior market share) and foreign operators can use competition policy to penetrate the economy by making official challenges against monopolistic behaviour of the established firms. The Cotonou Agreement commits the ACP-EU states to implement national or regional rules on competition policy. Article 51 notes that the competition policy is extended to the health sectors because it promotes the removal of barriers to trade in the context of 'consumer policy and protection of consumer health'. In effect, the commitment apparent in this aspect of the Agreement does not protect or promote the health sector in the ACP states as such, but rather provides for the liberalisation of the health sectors.

The focus of the IPR provisions of the Agreement is to ensure the effective protection of intellectual property rights. Article 46 of the Agreement speaks of adherence to the World Trade Organisation's (WTO) Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS) regime. The language of article 46 of the Agreement is such that the development-related concerns of the ACP states were never factored as a necessary dilution of the WTO regime as it stood in 2000 when the Cotonou Agreement was signed. The so-called TRIPS flexibilities emerged *after* the Cotonou Agreement was

signed, namely those regarding paragraph 17 of the Doha Declaration, November 2001 (Doha WTO Ministerial, 2001), Declaration on the TRIPS Agreement and Public Health, November 2001, the decision on Article 66.1 of the TRIPS Agreement, June 2002, the decision on Article 70.9 of the TRIPS Agreement, July 2002, and others that were taken between 2003 and 2008. The point to note is that, although overtaken by events at the WTO, the Cotonou Agreement in both spirit and substance was never meant to cater for the public health concerns of the IPR regime that ACP states were meant to adhere to. Even more important is the fact that, even though the TRIPS flexibilities exist in the context of the EPA negotiations, the EU negotiators are likely to attempt to dilute the flexibilities in the negotiation process, and every effort should be made by the ESA negotiators to mitigate this.

4.2 The ESA-EU Interim EPA

The IEPA between the ESA countries and the EU provides for modalities to govern trade in goods. It is however relevant for the purposes of this paper because it sets the general principles that are to govern the trade relations between the EU-ESA countries. The IEPA also sets the background for the negotiations in services, investment and other trade-related issues. The preamble to the IEPA recognises the following important issues that are pertinent to the question of health in the context of the EPA negotiations:

- The EPA should promote sustainable development and contribute to the eradication of poverty in the ESA states.
- It should be consistent with the objectives and principles of the Cotonou Agreement, in particular, the provisions of part III, title II.
- It must serve as an instrument of development.
- Its aims should be guided by the commitments of the international community towards achieving the Millennium Development Goals.
- Substantial investments are required to uplift the living standard of those living in ESA states.

This is, however, only the preamble, and the substantive sections of the IEPA make no specific mention of the needs of ESA countries' health sectors. In contrast, article 3 of the SADC-EU EPA clearly states that the application of the agreement shall fully take into account the human, cultural, economic, social, health and environmental interests of the population and future generations.

Chapter II of the IEPA makes provision for the liberalisation of trade in goods between the EU and ESA countries. Free trade in goods is to be achieved through a phased reduction of tariffs and other duties. The commitments made towards the liberalisation of trade in goods have an impact on health delivery systems in the ESA states because they cause revenue losses and a reduction in public funding for the states' health sectors (EQUINET et al, 2007). This point applies across all ESA states, even if the specific ESA country will not make any commitments with respect to trade in health services in the ongoing EPA negotiations. *Table 5* below shows the projected revenue losses accruing from the liberalisation of trade in goods in the ESA countries. The table shows significant revenue losses emanating from the EPA, with a direct impact on the amount of resources that ESA governments will have available for financing health.

Table 5: Projected revenue losses caused by trade liberalisation in Africa

Country	Projected annual revenue losses (US$)
Burundi	7,664,911
DRC	24,691,828
Ethiopia	55,126,359
Eritrea	7,385,208
Djibouti	37,523,124
Kenya	107,281,328
Madagascar	7,711,790
Malawi	7,090,310
Mauritius	71,117,968
Rwanda	5,622,946
Seychelles	24,897,374
Zimbabwe	18,430,590
Sudan	73,197,468
Uganda	9,458,170
Zambia	15,844,184

Source: Karingi et al, 2005.

The resulting reduction in revenue contradicts the spirit of article 25 of the Cotonou Agreement, which commits governments to ensuring that adequate levels of expenditure are implemented to sustain and develop the social sector, including the health delivery system. Once again, we should stress that the IEPA does not make specific or general provisions addressing the health sector in the ESA countries. One has to assume that health sector needs are included in the general promises for development, as contained in the articles that cater for development cooperation and the general objectives of the IEPA. For example, article 2(a) states that one of the objectives of the EPA is:

> *…contributing to the reduction and eventual eradication of poverty through the establishment of a strengthened and strategic trade and development partnership consistent with the objectives of sustainable development, the Millennium Development Goals and the Cotonou Agreement.*

Furthermore, article 38 states that the parties shall set out the development objectives related to the EPA that are specific to the ESA region and needed for the success of regional integration within specific sectors. Sectors covered under article 38 that are of relevance to this paper are services, including tourism, and trade-related issues, namely investment, competition, intellectual property rights, trade facilitation and statistics.

There are a lot of provisions with respect to development finance and capacity building, but these are phrased only generally and, where a specific sector is mentioned as a potential beneficiary, this is limited to certain sectors such as tourism and transport; however, the health sector is not mentioned. There is no provision or commitment in the ESA-EU IEPA that can be read as specifically protecting or enhancing the health sector in the ESA countries. The reference to the MDGs (which have a health component) in article 2 is not necessarily a tangible commitment by the IEPA to work towards the

implementation of the MDGs. A major shortcoming is the fact that no modalities for the realisation of the MDGs are set out in the IEPA.

Articles 3 and 53 of the IEPA form the basis of the current negotiations between the EC and the ESA group. Article 53 makes provision for the areas for future negotiations, including trade in services and trade-related issues, namely, those regarding competition policy, investment and private sector development, trade, environment and sustainable development, intellectual property rights and transparency in public procurement.

The inclusion of trade in services and the trade-related issues has direct significance for the health services sectors in the ESA countries. Article 53 leaves it open for ESA countries to elect to negotiate trade in health services and, if they do not elect to do so, the trade-related issues being negotiated will still have a direct impact on health services in the ESA countries. Therefore, liberalisation of the health sectors in the ESA countries will either take place in the context of the negotiations on services or those on trade-related issues. A combination of both methods of liberalisation is also possible.

5. Implications of GATS for the services negotiations

The negotiations for the comprehensive ESA-EU EPA take place against the background of the stalled Doha Round of the multilateral trade negotiations under the auspices of the World Trade Organisation (WTO). The WTO membership signed the General Agreement on Trade in Services (GATS) after realising the importance of services in international trade. The GATS provides for the progressive liberalisation of trade in services. However, one of the promises of GATS is to help developing countries participate in trade in services and expand their services exports by strengthening their domestic services capacity, efficiency and competitiveness. It is therefore important to assess the GATS developments and to link them with the current ESA-EU negotiations on services and trade-related issues. (For a more detailed discussion on the implications of GATS on health and equity in Southern Africa see EQUINET, SEATINI [2003].) Our discussion here will be limited to only those aspects of GATS that have a direct relevance on the EPA negotiations.

Article 1.2 of GATS defines trade in services as the supply of a service:

- from the territory of one member into the territory of any other member;
- in the territory of one member to the service consumer of any other member;
- by a service supplier of one member, through commercial presence in the territory of any other member;
- by a service supplier of one member, through presence of natural persons of a member in the territory of any other member.

Table 6 below illustrates these four modes of service delivery. Note that e-health (or telemedicine) is conducted over an open, transparent network, whereas telemedicine and telehealth are characterised more by point-to-point information exchange. E-health also includes public health services delivered over the internet, and use of electronic networks for health management and information systems.

Table 6: Modes of service delivery under GATS

Mode of service delivery	Description	Examples
Mode 1: Cross-border trade (GATS article I.2a)	Where trade takes place from the territory of country A into that of country B	• Telehealth • Passing of information by means of fax or e-mail
Mode 2: Consumption abroad (GATS article I.2b)	Services consumed by nationals of country A, in the territory of country B where the service is supplied (essentially the service is supplied to the consumer outside the territory of the country where the consumer resides)	• Consumers who cross borders to obtain medical treatment that might be cheaper or better than that available domestically • Tourism
Mode 3: Commercial presence (GATS article I.2c)	Where a service supplier of country A crosses the border to establish presence in country B and provide a service in country B	Establishment of a private hospital by a European company in Zambia
Mode 4: Movement of Natural Persons (GATS article I.2d)	Applies to natural persons only, when they stay temporarily in a foreign member's territory in order to supply a service	Doctors and other medical specialists who leave their countries to temporarily provide their services in other countries

The ESA countries that are members of the WTO have made a number of commitments under the GATS negotiations. Commitments may have been made in other sectors. However, only Burundi, Malawi, Rwanda, Zambia and the Republic of the Congo (Congo RP) have made GATS level commitments in the health sector. Other countries in the region are not bound by WTO level commitments to liberalisation of their health sectors and thus have the policy latitude to address this at national level.

The definition of services has implications for health delivery systems in the ESA countries. In almost all the ESA countries, the state is a major supplier of health services. Article 1.3 of GATS reads as if it excludes such state-provided services from the scope of the liberalisation thrust of GATS. The provision includes any service in any sector except for services supplied in the exercise of government authority. However, the same provision goes on to read:

> *A service supplied in the exercise of governmental authority' means any service which is supplied neither on a commercial basis nor in competition with one or more service suppliers.*

The state may not supply health services on a commercial basis but it certainly supplies them in competition with other suppliers such as for-profit private health care providers. This fact puts the public health services within the liberalisation scheme of GATS. Hence, within the context of the ESA-EU negotiations, public health services are treated just like any other service sector.

The Draft Comprehensive ESA-EU EPA attempts to modify the GATS scope of the definition of services providing that

> *Where a service is supplied in the exercise of governmental authority" means any service which may or may not be supplied on a commercial basis or in competition with one or more services suppliers.*

The rewording incorrectly limits the scope of the definition of services in the ESA-EU draft comprehensive EPA and the original GATS wording should be preserved.

Article V of GATS allows WTO Members to enter into regional trade agreements (RTAs). However there are requirements under this provision that have to be observed. RTAs within the GATS context must have substantial sectoral coverage, and they must provide for national treatment. Article V of GATS is a crucial provision and it has implications for the on-going ESA-EU negotiations on trade in services. It should be read with article V.3, which provides flexibilities against the requirements for substantial sectoral coverage and the national treatment where developing countries are part to an economic integration agreement.

5.1 Using flexibilities in the GATS agreement to help ESA countries

It is very important for the ESA countries, particularly those that have made health sector commitments, to take full advantage of the GATS article V flexibilities with regard to the requirement of 'substantial sectoral coverage'. The current ESA-EU negotiations require ESA countries to negotiate only one service sector. This arrangement takes advantage of the GATS flexibility. However, this is a partial fulfilment of this flexibility. The other aspect of this flexibility is the timing and sequencing of the negotiations for a full EPA that has substantial sectoral coverage on trade in services. Article V gives developing countries a 'reasonable time-frame' to achieve substantial sectoral coverage, but the length of the 'reasonable time-frame' is not provided.

In this respect it is pertinent to note that the draft ESA-EU comprehensive EPA reads:

> *No later than three years after entry into force of this agreement, the EC and each signatory ESA state will complete negotiations on services liberalisation on the basis of the following:*
>
> - *liberalisation schedule for one service sector for each participating signatory ESA state; and*
> - *agreement to negotiate progressive liberalisation with substantial sectoral coverage within a period of five years following conclusion of the full EPA.*

In restricting themselves to the above mentioned three-year and five-year time-frames, have the ESA states taken full advantage of the article V's flexibility in referring to a reasonable time-frame'? Probably not. The relative lack of experience and capacity that ESA countries have in trade in services (when compared with their EU counterparts) will probably mean that they will require more time to achieve the levels of coverage demanded by the ESA-EU EPA. It would have been better simply to have used the same 'reasonable time-frame' referred to in GATS in the ESA-EU EPA to allow for more flexibility for ESA countries.

Article V also gives developing countries flexibilities with respect to the elimination of existing discrimination in the services sector. Discriminatory measures are basically regulatory provisions that bar foreign services suppliers from operating at the same conditions with local providers. For example, it is possible for foreign service suppliers to be prohibited from investing in certain aspects of the health insurance sector. Developing countries are also given more room with respect to the prohibition of new or more discriminatory measures.

The draft ESA-EU comprehensive EPA has not taken full advantage of the above flexibilities. What remains is for the ESA states to identify the existing discriminatory measures and decide whether or not they should be maintained. Again, they need to assess their future legal needs and identify or plan for new discriminatory measures, within the scope of the current negotiations. Unfortunately, the draft arrangement has taken a position that is more restrictive than under the GATS – there is no need for ESA countries to adopt this position.

The GATS provides for national treatment, ie for the national treatment to a service supplier of any other member (of the WTO), that is, a legal person under the laws of the parties to an international agreement. The draft ESA-EU comprehensive EPA attempts to provide for more favourable treatment for intra-ESA service suppliers. This is good for ESA regional development. However it is very questionable whether this is permissible within the GATS context.

Article V.6 of GATS does not prevent the granting of more favourable treatment of service suppliers of parties to an economic integration agreement where that agreement involves only developing countries. However, the ESA-EU EPA involves both developing and developed countries, in this respect the granting of more favourable treatment to intra-ESA service suppliers is very questionable. In other words due to the nature of the ESA-EU EPA, the ESA states can only take advantage of the time-frame flexibilities under article V. This is a serious limitation.

The range of subsidies offered to the private health sector in industrialised countries differs from country to country. For example the UK government has been actively creating opportunities for the expansion of a once minor private health sector since 1996. Private health sector operators in the UK have been granted lavish cash-based subsidies towards start-up and other costs (UNISON, 2005). Marie de la Rama (2007) has traced the rapid rise of private equity investments in the health sector in Australia to generous government subsidies and argues that:

> *In 2005-2006, the Government spent Au$7.1 billion on aged care, of which Au$5.3 billion was for residential care subsidies. The average subsidy per place is Au$34,000. Multiply that figure by the number of beds owned by an aged care service provider and the amount comes to hundreds of millions of dollars in subsidies to the bigger players.*

Subsidies give private health sector providers from the rich countries greater advantages and a strong background from which to launch multinational investments. This can operate negatively where such service providers are competing with others from poorer countries.

This is the exact situation that will apply in the ESA-EU EPA when trade in services is liberalised. Article XV of GATS attempts to address the adverse effects of unfair subsidies. However, the ESA-EU EPA is not concerned with this issue as it provides that the 'provisions of this Title shall not apply to subsidies granted by the parties'. This puts ESA service suppliers at a distinct disadvantage. The WTO negotiations are stalled at the moment, and it is unreasonable to leave the entire issue of subsidies to the WTO framework when nothing substantial is happening at that level. Ideally, the ESA group should use the current EPA negotiations to raise their problems with subsidies that distort trade.

5.3 Issues concerning the modes of supply

Chanda (2002) identifies issues within each of the four modes of supply of health services:

- **Cross-border delivery:** Cross-border delivery of health services through telemedicine can enable health care providers to cater to remote segments of the population. But these gains are possible only if the requisite infrastructure is present. Given the lack of telecommunications and power sector infrastructure in many developing countries, telemedicine may not be cost-effective. In such cases, public sector resources may be better invested in improving basic health care facilities.
- **Consumption abroad:** This may enable exporting countries to improve their national health systems by generating foreign exchange and additional resources for investment in health care. But consumption abroad could also result in a dual market structure, by creating a higher quality, expensive segment that caters to wealthy nationals and foreigners, and a much lower-quality, resource constrained segment catering to the poor.
- **Commercial presence:** This can generate additional resources for investment in and upgrading of health care infrastructure and technologies; generate employment, reduce underemployment of health personnel; and provide expensive and specialised medical services. However, the gains from reduced pressure on government resources may be offset by the huge initial public investments that may be required to attract foreign direct investment into the health sector. This could also result in the development of a two-tiered health care system with a corporate segment and a public sector segment, the former concentrating on high-level technology and services that do not address broader social needs. A two-tiered system may also result in an internal “brain drain”, as better quality health care professionals flow from the public health care segment to the corporate segment, with its better pay and superior infrastructure. It may also lead to “cream skimming” whereby those who need less but can pay more are served at the expense of the poor and more deserving. These problems have occurred in countries such as Thailand, where there has been an increased outflow of service providers from the public to the private health sector, partly in response to the emergence of joint-venture private hospitals formed by local and foreign companies.
- **Movement of natural persons:** Increased mobility of health care providers can generate remittances and transfers and help promote the exchange of clinical knowledge amongst professionals. However permanent outflows of health care providers are likely to have adverse implications for equity, quality, and availability of health services in the source countries.

Across the four modes of supply of health services the ESA countries have only achieved some export experience in the movement of natural persons and have no infrastructure to speak of in respect of the other modes of supply. The migration of health workers from ESA countries to the EU is an issue that has been raised at bilateral and multilateral level, and ESA states will need to ensure consistency with positions in these forums and their commitments in the services negotiations.

5.4 Excluding health services from trade liberalisation

There is an argument for excluding the health services sector from trade liberalisation, given the need for non-market measures for protecting access to health, equity and for financial protection of the poor. This argument has already prevailed in the caution being

exercised over committing health services under the GATS. The only ESA countries that have made commitments in the health sector under the GATS process are Malawi and Zambia. The two countries have fully liberalised the health sector within the GATS context. At this stage it is not clear if any other ESA country is contemplating making such commitments at the stalled GATS level, or under the current ESA-EU negotiations.

The current process demands that ESA countries should pick one service sector for liberalisation. Ultimately, these countries will have to make commitments that have 'substantial sectoral coverage' for the purpose of meeting the requirements of article V of GATS. However, article V does not prevent the total exclusion of an entire sector from liberalisation. The note to article V.1(a) defines 'substantial sectoral coverage' as meaning liberalisation based on the 'number of sectors, volume of trade affected and modes of supply. In order to meet this condition, agreements should not provide for the a priori exclusion of any mode of supply.' In other words, GATS is concerned with the fact that regional trade agreements (RTAs) should not exclude any mode of supply from the commitments made by the member states.

Given that most ESA countries did not make commitments in the health sector under GATS, they can still rely on their GATS positions as the basis for not opening negotiations in this sector within the EPA context. Article V of the GATS does not prevent the exclusion of an entire sector from liberalisation. Even if this does lead to an an accusation that a RTA is inconsistent with the requirement for 'substantial sectoral coverage', not all ESA countries are members of the WTO, and asking these countries to submit to the liberalisation process that complies with the WTO rules forces them to take on obligations that they never signed up to.

What is important to note under this section is the fact that ESA countries are under pressure to eventually liberalise all their services sectors under the EPA context. Unless the health sector implications are carefully managed, this creates a faster pace of liberalisation than that which obtains currently under the WTO process.

6. Recommendations for the services negotiations in the IEPA

Arising from the evidence in this paper there are a number of issues that ESA countries should consider in the process of negotiations on trade in services, in particular health services. ESA countries also need to identify the opportunities and risks attached to each mode of supply of services and position themselves to maximise the opportunities and minimise the risks.

6.1 Negotiating content in the EPA

As a guiding principle, it is suggested that ESA countries use human rights as a basis for the protection of health and health care services in the EPA. This is argued given the existence of clear international, regional and national commitments that recognise health as a human right, as presented in this paper. Both ESA and EU countries are signatory to these international commitments and the EPA must be compliant with them. There are specific protections for public health and health care services within them and these need to be respected. Furthermore, ESA countries have such protections in their constitutions and laws that need to be noted in any trade negotiations.

The ESA countries should ensure that there is a clause protecting public health and recognizing state obligations to protect universal and equitable access to health services through the public sector in the EPA content. This can be achieved by inserting a clause in the EPA that not only excludes the liberalisation of the health sector, but that also recognizes the priority for protection of public health as a guiding principle as in the EU-SADC IEPA and commits the parties to allowing government authorities and availing specific resources to the public health sectors of the ESA countries as part of the development dimension of the EPA. This protection should include a firm commitment by the EU to avail funds to ESA countries to counter the effect of revenue losses due to the liberalisation of trade in goods.

We further argue that the negotiating content should ensure the adoption of measures to strengthen the regulatory capacities of ESA states with respect to the operations of the private health sector.

Above all, it is necessary to insist that impact assessment studies should be conducted and publicly reported on and a review clause inserted in the EPA to ensure that public health is not compromised as a result of the liberalisation thrust of the EPA.

To achieve the above four points, the ESA negotiating content should include the inclusion of these issues as part of the EPA clauses.

6.2 Further issues

Further to the core content and approaches above the analysis of the background commitments and agreements in the context of high demand for public sector leadership in health services in poor and vulnerable communities in ESA raises a number of issues that need to be integrated within the services negotiations. The policy demand for equity in health calls for implementation of article 25 of the Cotonou Agreement committing the ACP-EU parties to make available adequate funds for:

- improving health systems and nutrition, eliminating hunger and malnutrition, ensuring adequate food supply and security;
- integrating population issues into development strategies in order to improve reproductive health, primary health care, family planning; and prevention of female genital mutilation;
- promoting the fight against HIV/AIDS; and
- increasing the security of household water and improving access to safe water and adequate sanitation.

A specific need to address the major ill health and maternal mortality burdens in women calls for implementation of article 31 of the Cotonou Agreement, which encourages the adoption of specific measures in favour of women such as access to basic social services, especially education and training, health care and family planning.

It is necessary to place the health sector as part of the development chapter of the comprehensive EPA, and of implementation of article 34 of the Cotonou Agreement. This entails the negotiation of technical and development finance assistance targeted at the health sector as part of the sustainable development cooperation as envisaged under article 34 of the Cotonou Agreement.

As discussed by previous authors (e.g. Munot, 2000; Loewenson, 2001; Muroyi et al, 2003; Machemedze, 2003; EQUINET and SEATINI, 2003; 2006; 2007), negotiators also need to ensure that the TRIPS references in the Cotonou Agreement are used to implement flexibilities for ESA countries rather than to promote only the interests of the EU companies. This should also mean that ESA countries do not adopt TRIPS-plus commitments, e.g. data exclusivity.

Negotiating bilateral agreements on the movement of health personnel should be done in line with the resolutions of the Regional Health Ministers Conferences of the East, Central and Southern African Health Community, the World Health Assembly's Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property (May 2008), the Kampala Declaration and Agenda for Global Action (March 2008), with consideration of issues such as:

- taxation of health professionals from ESA countries who migrate to the EU;
- a proportion of their taxable income that should be remitted by the EU states to the source country;
- financial compensation to ESA countries for the loss of health professionals who migrate permanently to the EU; and
- provision of technical assistance to the ESA health professionals training centres.

Investment rules need to be negotiated to channel resources into the ESA health sector according to the identified needs of the ESA countries. These include requirements for private investors to provide a certain level of primary health care for free or at reduced rates to cater for the vulnerable communities in the ESA countries and requirements for the private sector to extend health care facilities to rural and remote communities within the ESA states for the purpose of strengthening and complimenting the public health sector.

Negotiators from ESA should provide for a framework agreement for the EU to remove subsidies that distort trade in health services and put ESA service suppliers at a disadvantage. Such rules should be agreed upon before any commitments are made by ESA countries. Further the services negotiations should be clearly framed within the rights of countries to not commit their health sectors under GATS or any other trade liberalization agreements, to maintain government authorities in these areas and to use the flexibilities offered to ESA countries under article V of the GATS, particularly to:

- create longer periods for the achievement of substantial sectoral coverage, e.g. 15–20 years (or ESA countries may insist on setting substantive benchmarks, e.g., as contained in the MDGs);.
- create longer periods for ESA countries to apply other article V (GATS) flexibilities, e.g. on the prohibition of new discriminatory measures and the elimination of existing ones; and
- secure the EU's commitment to support ESA states with respect to any WTO concerns on the application of article V.6 of the GATS.

The above issues can be used to put more substance to the current ESA-EU draft on the in-built negotiations on services and trade-related issues. At present there is not much substance in the draft, and it does not appear as if the development concerns of the ESA countries have been considered.

6.4 Postscript: The status of the negotiations

At the time of writing this paper the negotiations for a full ESA-ESA EPA were meant to have been concluded in December 2008. In March 2008 the EC-ESA EPA Trade Ministerial Meeting held in Lusaka, Zambia agreed on a roadmap to reach, at the end of 2008, an agreement on a comprehensive EPA. This comprehensive EPA was expected to also deal with agreements on the services negotiations.

The agreed roadmap was not accomplished and the meetings that had been scheduled for December 2008 were postponed to January 2009. Negotiations are expected to continue in 2009 on the basis of another roadmap that is yet to be agreed upon. Concrete positions on trade in services are still an outstanding issue and under negotiation at the time of writing with little information made publicly available on the terms and debates in those negotiations.

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Acronyms

ACP	African-Caribbean and Pacific
ACP	Afro-Carribean Pact
CAT	Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
CCPR-OP1	Optional Protocol to the International Covenant on Civil and Political Rights
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CEDAW-OP	Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women
CERD	International Convention on the Elimination of All Forms of Racial Discrimination
CESCR	International Covenant on Economic, Social and Cultural Rights
CCPR	International Covenant on Civil and Political Rights
CRC	Convention on the Rights of the Child
CRC-OP-AC	Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict
CRC-OP-SC	Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography
EPAs	Economic Partnership Agreements
EQUINET	Regional Network for Equity in Health in east and southern Africa
EU	European Union
GATS	General Agreement on Trade in Services
IPRs	Intellectual property rights
IEPA	Interim Economic Partnership Agreement
MDGs	Millennium Development Goals
MWC	International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families
COMESA	Common Market of east and southern Africa
NEPAD	New Partnership for Africa's Development
OAU	Organisation of African Union
OECD	Organisation for Economic Co-operation and Development
RTAs	Regional trade agreements
SADC	Southern African Development Community
SEATINI	Southern and Eastern African Trade Information and Negotiations Institute
TRIPS	Trade Related Aspects of Intellectual Property Rights
TARSC	Training and Research Support Centre
UN	United Nations
WTO	World Trade Organisation

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

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

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

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