THE LEGAL IMPLICATIONS FOR THE NHS OF TRANSATLANTIC TRADE AND INVESTMENT PARTNERSHIP

Executive Summary

The following advice shows that there are real risks arising from the TTIP that could impact on the NHS unless a robust carve-out is put in place. Some key points from the advice are:

- The EU and US rationale which underpins the TTIP perceives 'welfare' in such a way as to include the preservation of consumer and health standards but with no reference whatsoever to the protection of the underlying social and health protection systems like the NHS.
- The protections in the General Agreement on Trade in Services (GATS) and the EU-Canada trade agreement (CETA) applying to "services supplied in the exercise of governmental authority" do not appertain to NHS services. This is clear because of the competitive co-existence of public and private providers in the NHS as well as the private funding and commercial activities of NHS Foundation Trusts.
- Claims that the NHS will be protected as a 'service of general economic interest', a 'public utility', and/or a 'public service' are unfounded because this would still leave it included in the material scope of the TTIP and subject to the full gamut of obligations in the agreement, except for certain features of the market access principle.
- The NHS is subject to numerous obligations under the CETA (mostly to the fair and equal treatment standard and to the principle of protection against unlawful expropriation) that could trigger an investment claim if the UK Government modifies the legal and business environment for healthcare-related investors. The NHS will be in the same position under TTIP unless it is fully and clearly exempted.
- The potential impacts of the TTIP on the NHS are not solely dependent on Investor-State Dispute Settlement (ISDS) being in place. However, the European Commission and the UK Government have been insisting on its inclusion and this will increase potential risks.
- ISDS as perceived in the CETA would allow healthcare-related investors to bring cases against the UK Government and to bypass domestic courts. Said cases will be judged by arbitrators lacking in independence and democratic legitimacy, in procedures subject to confidentiality with no appellate mechanism. It would also promote the risk of suppressing future legislation through the phenomenon of 'regulatory chilling'.
- Under an investment treaty such as the TTIP, which potentially includes investor protection with the threshold of providing 'full restitution' in case of unlawful expropriation, future lost profits can be compensated for as well as the actual value of the property taken. Overall, the expropriator´s responsibility is increased once a taking is considered to be unlawful not only on the basis of UK law but also on the basis of an investment agreement.
- To fully and clearly exempt the NHS from TTIP would require a robust 'carve-out' of the NHS from the material scope of the agreement. This would ideally be done on the basis of a

blanket exception inserted in its main text but could also potentially be achieved within the context of a carefully drafted Annex II reservation.

- In the UK's Annex II reservations concerning health services in CETA, the UK decided to expose public ambulance services and all secondary care services (i.e. hospital services, public or private) to the liberalising effect of the agreement and not to submit any reservation whatsoever in this respect. This is a worrying precedent for the TTIP.
- When the TTIP final text is complete, it will have to be adopted and ratified by the European Parliament and the EU Member States, respectively; however the role of national Parliaments is unclear and may have to be decided by the Court of Justice of the EU.
- Member States have to agree unanimously in the European Council on any trade agreement that risks "seriously disturbing the national organization of [social and human health] services and prejudicing the responsibility of Member States to deliver them". However, there is no clear definition of when this applies.

INTRODUCTION

1. This advice has been commissioned by Unite the Union to address the legal repercussions of the Transatlantic Trade and Investment Partnership (TTIP) between the European Union and the United States of America for the NHS. TTIP is currently under elaboration by the European Commission and is purposed to constitute a comprehensive trade and investment agreement.

2. Given the pendency and the present unavailability of a conclusive text on the TTIP, the present legal analysis shall be based on the available soft law instruments (such as Communications from the Commission) as well as on juxtapositions that may be drawn on the basis of pertinent, analogous international agreements and more specifically on the basis of the Comprehensive Economic and Trade Agreement between Canada and the EU (CETA) draft text and the General Agreement on Trade in Services (GATS).

TTIP AND HEALTHCARE SERVICES: THE INSTITUTIONAL FRAMEWORK

3. The scope of common commercial policy concerning trade in services has been subject to disputes between the Member States and the EU. This controversy has now been resolved in Articles 206-207 TFEU. The EU, after the entry into force of the Treaty of Lisbon, is exclusively competent to agree and implement trade agreements relating to services with non-EU States. Furthermore, the material scope of the common commercial policy also includes now, on the basis of Article 206 TFEU, the progressive abolition of restrictions on international trade and on foreign direct investment.

4. The sectoral carve-out, which was included in ex. Article 133(6)(2) ECT for inter alia social and human health services has been abandoned and the EU is now exclusively competent for the negotiation and the implementation of these agreements. This actually entails that, in principle, the national Parliaments will no longer be able to ratify the pertinent agreements, unless elements of the said agreements are valued as matters of mixed competence, i.e. shared between the EU and the Member States, in which case ratification

by the national Parliaments may be required for certain parts of these agreements. It is noteworthy that under the European Community Treaty (ECT), social and human health services were excluded from the exclusive competence for the common commercial policy and fell within the shared competencies of the Community and the Member States.

5. At the same time, under the TFEU, the EU still holds very limited competencies in the field of health care, given that in Article 168§7 TFEU, it is explicitly defined that "*Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organization and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them*".[1] Therefore, on the basis of the common commercial policy competence of the EU, the latter is exclusively competent to negotiate and conclude trade and investment agreements relating to healthcare, whereas, simultaneously on the basis of the internal delimitation of competencies, the management of health services and medical care is a matter of national concern. In that regard, an EU external competence has been established *without* an internal counterpart, resulting in a constitutional discrepancy.

6. Overall, the aforementioned, relatively unfledged competence of the EU shall be exercised as follows: at the outset, the European Parliament and the Council, acting by means of regulation, in accordance with the ordinary legislative procedure shall adopt the measures defining the framework for implementing the common commercial policy.[2] Furthermore, on the basis of Article 218 TFEU, the Council on a proposal by the Commission shall adopt a decision concluding the agreement, only after obtaining the consent of the European Parliament, which now has a veto right.

7. Apart from vetoing a trade and investment agreement, Article 218§11 TFEU provides that "*A Member State, the European Parliament, the Council or the Commission may obtain the opinion of the Court of Justice of the EU as to whether an agreement envisaged is compatible with the Treaties. Where the opinion of the Court is adverse, the agreement envisaged may not enter into force unless it is amended or the Treaties are revised".* Hence, the Court of Justice of the EU (CJEU) may become the final arbiter.

8. At the level of concluding the agreement, it is not clear yet which procedure will be followed by the Member States within the Council; actually, Article 207(4)(b) TFEU requires, by way of derogation from the qualified majority rule, unanimity in the Council for the conclusion of trade agreements concerning social and health services "*where these agreements risk seriously disturbing the national organization of such services and prejudicing the responsibility of Member States to deliver them*". This latter provision in the Treaty is a trade-off between, on one hand, the abolishment of the previous carve-out for social and

[1] Equally, Article 35 of the Charter of Fundamental Rights, having the same status as the TFEU, proclaims that "Everyone has the right of access to preventive health care and the right to benefit from medical treatment *under the conditions established by* ***national*** *laws and practices* [emphasis added]".
[2] See Article 207(2) TFEU.

health services and, on the other hand, the need to protect such a politically delicate sector of the economy from any liberalizing effects.[3]

9. The aforementioned "disturbance of the national organization and prejudice towards the responsibility of Member States to deliver [healthcare services]" as a prerequisite to unanimity is a very vague notion and could, perhaps, be regarded as an exercise of rhetoric in the Treaty, while, at the same time, the conclusion of the pertinent agreements will be subject, for rather operational reasons, to the ordinary qualified majority.[4]

10. Indeed, sophisticated interpretations on the meaning of the expression "disturbance of the national organization and prejudicing the responsibility of Member States to deliver [healthcare services]" may be proposed to loosen the unanimity rule, especially given the fact that there is no hard law EU-consensus as to its exact meaning and that in the pertinent case-law of the CJEU reference to the *national a*spect of healthcare delivery is hardly ever made.

11. This new inclusion of health services as an exclusively EU external competence without an internal counterpart may be in the position of pre-empting the field and of compromising the exercise of an internally national competence. It is, thus, evident that if the Members of the Council are to have any certainty about their competence in this respect, they will need to unequivocally define under which circumstances agreements such as the GATS, CETA and TTIP would risk impinging on the organization of social and human health services in individual Member States and on the responsibility of the latter for their provision. .

12. To that effect, there is a consensus only at an intergovernmental level; the Conclusions of the Council 1-2 June 2006 on "Common Values and Principles in European Union Health Systems"[5] have set the operating principles that are shared by health systems throughout the EU. Thereby the following are proclaimed as overarching principles: universality, access to good quality care, equity and solidarity. Furthermore, it is thereby clarified that decisions about the mechanisms used to finance and deliver healthcare, such as the extent to which it is appropriate to rely on market mechanisms and competitive pressures to manage health systems, must be taken within the national context.[6] These statements, albeit they sound promising, do not constitute a solid mechanism capable of ring-fencing universality and/or the public character of the NHS**.**

[3] The same degree of cautiousness is also to be found in Art. 2(2)(f) of the Services´ Directive 2006/123/EC, whereby "healthcare services whether or not they are provided via healthcare facilities, and regardless of the ways in which they are organized or financed at national level or whether they are public or private" are exonerated from the material scope of the Services´ Directive.

[4] See Markus Krajewski, *Protecting a shared value of the Union in a globalised world: Services of general economic interest and external trade* in J.Van de Gronden (ed.), *The EU and WTO Law on Services,* Kluwer Law International, 2009, pp. 191.

[5] OJ C 146, 22.06.2006.

[6] Ibid, pp.2.

TTIP: WHAT IS IN IT FOR HEALTHCARE?

13. The TTIP is purposed to constitute a bilateral trade and investment treaty between the EU and the US. According to its credo,[7] the volume of bilateral trade in services and in investment in services should be increased by reducing barriers to market access. As to the overall estimation of changes in welfare for the EU and the US, the rationale underpinning the TTIP is that "*the greater the extent of liberalisation proposed, the greater are the estimated welfare gains*".[8] It is important to note that although 'welfare' is perceived in such a way as to include the preservation of consumer and health standards, no reference is made whatsoever to the underlying social and health protection systems.

14. But how exactly could a bilateral trade and investment agreement like the TTIP endanger the public character of a national health system? The conundrums to be dealt with could be summarized as follows:

15. First, the TTIP could serve as a market-opening tool capable of obliging national contractual mechanisms to open up to U.S.-domiciled healthcare providers, and mostly, to private and profit-oriented-rivals of the incumbent, public providers. These providers will be incentivized to focus on the economically profitable sectors of the pertinent market and embark on risk-selection (cherry-picking) on the basis of population density and health risks.

16. Actually, according to the as of October 2014 "Directives for the negotiation on the TTIP between the European Union and the United States of America",[9] "the Agreement will aim at enhanced mutual access to public procurement markets at all administrative levels (national, regional and local), and in the fields of public utilities, covering relevant operations of undertakings operating in this field and ensuring treatment no less favourable than that accorded to locally established suppliers".

17. This is a particular risk for benefit-in-kind, Beveridgian systems, such as the traditional NHS. This is because such systems heavily rely on planning based on block contracts and a solid network of local providers. Although the EU judiciary has conceded that excluding a provider from the public network of contracted providers is contrary to the internal market rules,[10] at the same time, it has indicated throughout the case-law that healthcare subject to planning as well as the closed contractual arrangements of benefit-in-kind systems need to be ring-fenced:.[11] Actually, the CJEU has conceded that supply-induced demand necessitates resort to a net of incumbent providers and that new entrants in healthcare systems could

[7] See Commission Staff Working Document, Impact Assessment Report on the future of EU-US trade relations, Accompanying the document "Recommendation for a Council Decision authorising the opening of negotiations on a comprehensive trade and investment agreement, called the Transatlantic Trade and Investment Partnership, between the European Union and the United States of America", Strasbourg, 12.3.2013, SWD(2013) 68 final, COM (2013) 136 final.

[8] Ibid, pp. 50.

[9] http://data.consilium.europa.eu/doc/document/ST-11103-2013-DCL-1/en/pdf, paragraph 24.

[10] See Case C-456/05 *Commission v. Germany* [2007] ECR I-10517.

[11] See, indicatively, Cases C- 157/99 *Geraets-Smiths and Peerbooms* [2001] ECR 5473, C-169/07 *Hartlauer* [2009] ECR I-1721, Joined Cases C-570/07 and C-571/07 *Blanco Pérez and Chao Gómez v. Consejeria de Salud y Servicions Sanitarios and Principado de Austurias* [2010] ECR I-4629 and C-217/09 *Ottica New Line di Accardi Vincenzo v. Comune di Campobello di Maraza* [2010] ECR I-0175.

jeopardize the financial stability of a system that operates in full capacity and could lead to risk-selection.

18. Second, the TTIP, in the absence of a safety net for the NHS, might entail compensation requirements if a State decides to unilaterally redefine the borderline between public and private healthcare provision in favour of the public sphere. In this context it is notable that for the purposes of EU Law, and especially in so far as proprietorship rules (shareholders´ requirements) in the healthcare provision sector are concerned, the EU judiciary has clarified that although the EU rules do not impose as such a concrete obligation to liberalise, once the Member States have done so, they open that activity to market forces and are accordingly bound by EU rules.[12]

19. In July 2014, the Commission issued online a press release entitled "Protecting Public Services in TTIP and other EU trade agreements",[13] whereby it clarifies that national governments have to treat U.S. companies that have already been allowed to operate in the EU in the same way as they treat EU ones, without explaining, though, in which circumstances such an operation may allow U.S. companies to avail themselves of the EU public procurement law a*cquis.* In the same press release, the Commission states that it has already initiated a procedure according to which in some agreements forming part of the TTIP, each Member State shall specify a positive list of public services (including healthcare ones) that it will open up to U.S.-domiciled suppliers, whereas in other agreements, all services shall in principle be subject to the rigour of the TTIP and shall open-up to non-EU investors, except those enlisted in the negative list, as designated respectively by each Member State. Next, the Commission refers to a typology of publicly-funded healthcare and social services which includes: (a) Hospitals; (b) Ambulances; (c) Residential health facilities; (d) Welfare services for children and the elderly and (e) benefits for disabled people.

20. It is thus more than evident that a wide range of healthcare services are included in the material scope of the TTIP and, more specifically, to its substantive and procedural aspects, as articulated below.

THE MARKET OPENING TOOLS IN THE TTIP: SUBSTANTIAL ASPECTS

21. The main market-opening tools to which bilateral treaties resort for the purposes of facilitating trade and investments may be divided into two clusters; the s*ubstantial* aspects of investment protection and its *procedural* aspects.[14] I shall begin with the former, which encompass the principles of market access, non-discrimination, the principle of fair and equitable treatment and protection against unfair expropriation.

[12] Case C-141/07 *Commission v. Germany* [2008] ECR I-6935.
[13] http://trade.ec.europa.eu/doclib/press/index.cfm?=115
[14] See for this distinction, Markus Krajewski, *Modalities for investment protection and Investor-State Dispute Settlement (ISDS) in TTIP from a Trade Union perspective,* Friedrich Ebert Stiftung, EU Office Brussels.

22. **Market access**[15] obliges the signatories to an investment agreement to refrain from adopting and/or to eliminate barriers to trade, such as quotas, monopolies, restrictions on the number of suppliers, their turnover or assets, joint-venture requirements or foreign equity ceilings as well as limitations on the total value of foreign investment. A further feature of the market access obligation is the prohibition of the economics needs test (ENT). ENT encompasses regulatory measures (like quantitative or territorial restrictions) which limit the number of service providers on the basis of economic considerations with the purpose of controlling, in the case of healthcare provision, supply-induced demand. Public healthcare systems inherently and by definition resort to territorially closed and selective contracting out of benefit providers, price-fixing, compulsion and public monopolies. Therefore the imposition of the market access obligation on national governments deprives them of regulatory instruments, which are crucial for the purposes of alleviating moral hazards, risk selection practices and information asymmetries. The latter are of particular importance as they can predominate in an unregulated and competitive healthcare market. Furthermore, due to the market access obligations, government bodies may feel compelled to conduct competitive tenders in such a way as to favour the most cost-efficient bidder, to the detriment of bidders offering higher service quality.[16]

23. The principle of **non-discrimination**[17] further encompasses two sub-principles: the most-favoured nation treatment (MFN), which should not raise particular issues for the purposes of the present discussion, and national treatment, on which we shall hereby focus.

24. **National treatment** is concerned with indirect discrimination. It involves the elimination of requirements which, while apparently nationality-neutral on their face (same burden in law) have a greater impact on foreign investors-companies (different impact in fact). Therefore, even indistinctly applicable general laws or measures potentially impeding access to a national market are in the position of constituting a violation of the non-discrimination principle. A broad definition of de facto discrimination may reduce host states´ ability to introduce regulatory or fiscal differentiations justified on the basis of legitimate policy objectives,[18] such as the preservation of the financial viability of a public health system.

25. The principle of **fair and equitable treatment**[19] **standard** represents the most important and most elusive obligation imposed on States. Features of said principle may encompass from time to time a strict requirement on the host state to maintain a stable legal and business environment[20] as well as the protection of investor´s legitimate expectations especially in fields, whereby States do not exercise their governmental authority, but are engaged in economic activities (the services provided by the NHS of the UK may well qualify as such).

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[15] See Section 2 (Establishment of Investments), Article X.4. on "Market Access" as well as Article X.5. on "Performance Requirements" of the consolidated CETA text, as of September 2014, available at http://trade.ec.europa.eu/doclib/docs/2014/september/tradoc_152806.pdf

[16] See Markus Krajewski, *Public services in EU Trade and Investment Agreements,* 14 November 2013, available at http://www.epsu.org/IMG/pdf/Draft_report_Markus_Krajewski_mtg14Nov2013.pdf.

[17] See Section 3 (Non-Discrimination Treatment), Articles X.6. and X.7. as well as Annex X of the consolidated CETA text, as of September 2014.

[18] See e.g. *Occidental v. Ecuador,* Award 1 July 2004.

[19] See Section 4, Article X.9. ("Treatment of Investors and of Covered Investments") of the consolidated CETA text as of September 2014.

[20] See e.g. *LG & E Energy v Argentina,* ICSID Case No. ARB/02/1, Decision on Liability, 3 October 2006.

These obligations are as such very wide in scope, susceptible to differing interpretations and may significantly restrain the host states´ ability to modify domestic legislation or to adapt it over time (**regulatory chilling effect**).[21]

26. In the CETA, a further impetus towards a regulatory chilling effect is added; more specifically, it is provided that "*When applying the…fair and equitable treatment obligation, a tribunal may take into account whether a Party made a specific representation to an investor to induce a covered investment, that created a legitimate expectation, and upon which the investor relied in deciding to make or maintain the covered investment, but that the Party subsequently frustrated*".[22] On the basis of arbitral decisions, it is suggested that legitimate expectations may be derived either from:
    a. Specific commitments addressed to particular investors or
    b. Regulations that albeit not addressed to particular investors, have been adopted with the aim of inducing foreign investments.

27. These 'legitimate expectations', albeit opaque as a concept, are clearly connected to the phenomenon of change. Claims relating to breach of legitimate expectations arise in situations when an investor is suffering losses due to the changes occurred due to certain State measures. For instance, a newly elected government having a different policy perspective, e.g. on privatizations, from its predecessor may potentially trigger the implementation of the fair and equitable standard.[23] In this regard, it is important to underscore that the CETA does not provide explicit rules aiming at balancing investors' expectations against legitimate regulatory action.

28. **Protection against expropriatory takings**[24] is one of the most controversial provisions in the investment protection system. *Direct* expropriation occurs when an investment is nationalized or otherwise directly expropriated through formal transfer of title or outright seizure.[25] Direct expropriations may take place indicatively when a government takes over a private entity (e.g. a private healthcare provider/hospital), depriving the investor of the benefits of ownership and control, in case of a compulsory transfer of property rights from investor to the State and/or via the nationalization of an entire industry sector (e.g. healthcare).

29. Indirect-regulatory expropriation entails regulatory measures (for instance a regulatory body´s decision on the marketing authorization, pricing and/or reimbursement of a pharmaceutical product) which aim at the protection of a legitimate public interest and which, at the same time, deprive the investor of the commercial value of the investment.[26]

[21] See e.g. *CMS v Argentina, ICSID Case No. ARB/01/8,* Award of 12 May 2005.
[22] See paragraph 4 of Section 4, Article X.9. ("Treatment of Investors and of Covered Investments") of the consolidated CETA text as of September 2014.
[23] See *Vivendi v. Argentina II,* ICSID Case N.ARB/97/3, Award, 20 August 2007.
[24] See Section 4 (Investment Protection), Article X.11. as well as Annex X.11. of the consolidated CETA text as of September 2014.
[25] See Annex X.11 (Expropriation), §1 indent 1 of the consolidated CETA text as of September 2014.
[26] See *Compania de Desarrolo Santa Elena S.A. v. Costa Rica* [2000] Award 39 ILM 317 72 (ICSID) and *Metalclad Corporation v United Mexican States*, ICSID Case No. ARB (AF)/97/1, Award of 30 August 2000.

30. In the Commission´s "Public Consultation on Modalities for Investment Protection and ISDS in the TTIP"[27] as well as in the CETA, indirect expropriation is considered to be a measure or a series of measures with an effect "equivalent to direct expropriation, in that it substantially deprives the investor of the fundamental attributes of property in its investment, including the right to use, enjoy and dispose of its investment, without formal transfer of title or outright seizure". At the outset, this definition is very broad in scope and leaves a wide margin of appreciation for investment tribunals as to the assessment of the occurrence of indirect expropriation on a case-by-case basis. Apart from that, it is generally argued[28] that only a *narrow* category of takings in the public interest are considered as non-expropriatory, and those takings are especially those which occur within the context of exercising governmental authority, which does not appertain to the NHS.

31. In the aforementioned Consultation as well as within the context of the CETA, albeit it is clarified that measures designated to protect public welfare objectives, including health, do not in principle constitute indirect expropriations, it is nonetheless conceded that there shall be cases whereby said measures might appear to be manifestly excessive, i.e. go beyond what is necessary for the attainment of a public welfare objective. In such a case, investment tribunals will be called upon to implement the proportionality principle and embark on a cost-benefit analysis. This vests investment tribunals with the authority to review domestic legislation in light of its welfare benefits and of the costs generated to investors.[29]

32. An expropriation (direct or not) may be lawful or unlawful, depending on a wide array of factors. In principle, an expropriation is lawful if it is made for a public purpose, in a non-discriminatory manner, satisfies due process and the required compensation is paid. If any of these requirements are not satisfied, it is unlawful. Whether lawful or not, the expropriation must not violate the fair and equitable obligation and must be compensated. The key difference lies in the fact that lawful expropriation requires payment of the fair market value of the investment at the date of the taking, whereas unlawful expropriation amounts to a breach of the investment treaty, obliging the host State to make full restitution, possibly including future lost profits. Overall, the expropriator´s responsibility is increased once a taking is considered to be unlawful not only on the basis of national law but also on the basis of an investment agreement.

33. In any case, and further to the constraints on regulatory autonomy that the insertion of the prohibition of unfair expropriation in the TTIP may result in, it has been contented that the EU cannot negotiate clauses on expropriation, as such clauses would change the delimitation of competencies according to Article 345 TFEU.[30] Article 345 TFEU provides that the Treaties shall in no way prejudice the rules in Member States governing the system of property ownership; and this holds all the more true in the healthcare sector, whereby the

[27] http://trade.ec.europa.eu/doclib/docs/2014/march/tradoc_152280.pdf, pp.24-25.

[28] See Jan H. Dalhuisen and Andrew T. Guzman, *Expropriatory and Non-Expropriatory Takings under International Investment Law.* Available at http://ssrn.com/abstract=2137107

[29] See also Peter Muchlinski et al., *Statement of concern about planned provisions on Investment Protection and ISDS in the TTIP,* available at http://www.kent.ac.uk/law/isds_treaty_consultation.html

[30] See, also, Federico Ortino and Piet Eeckhout, *Towards an EU Policy on Foreign Direct Investment* in: Andrea Biondi, Piet Eeckhout and Stefanie Ripley, *EU Law After Lisbon,* OUP, 2012, pp. 312-327.

EU holds limited competencies. Overall, it is settled[31] that Article 345 TFEU only concerns the public or private ownership of undertakings with which the EU shall not concern itself and which can, thus, be regulated by the Member States themselves.

34. Albeit this is a seemingly strict prohibition, the CJEU has rarely accepted arguments based on this provision and has not been able to construe it as a strict limitation. In the fairly recent case of *Essent*,[32] whereby the CJEU had to assess the compatibility with EU Law of an absolute privatization ban, albeit it was, in principle, held, on the basis of Article 345 TFEU, that Member States are free to decide that the right to carry out certain activities in the energy sector may be solely granted to undertakings of public ownership, at the same time, it was conceded that the right of the Member States to determine their system of property ownership is not unrestricted; they must also abide by the fundamental principles of EU Law and more specifically by the free movement principles.

THE MARKET OPENING TOOLS IN THE TTIP: PROCEDURAL ASPECTS

35. The Commission, in its capacity as the negotiator of the TTIP, has been insisting on the inclusion of the Investor-State Dispute Settlement (ISDS) as an enhanced mechanism for investment protection. The potential impacts though of the TTIP on the NHS are not solely dependent on ISDS being in place. It could still be the subject of rulings by national courts, implementing an investment agreement, or State to State Investment Treaty arbitration. Nonetheless, ISDS has particular characteristics and it is notable that in the CETA, ISDS has already been inserted.[33] ISDS is based on the premise that foreign investors have been vested the right to directly sue the state in which they have invested (the host state), in the case where it is considered that the host state violated the substantial provisions of the investment treaty. The distinctive features of ISDS are the following:
    a. This dispute settlement mechanism **does not have an inter-state character** and investors may bypass any procedures involving their home state;

    b. There is **no requirement that the investors, availing themselves of ISDS, seek redress in domestic courts** or exhaust local legal remedies before turning to an international tribunal. Actually, in the CETA, the pertinent provisions oblige investors to choose between domestic courts and international arbitration tribunals.[34]

    c. Investment tribunals award **compensation in the form of monetary damages**, whereas claims or proceedings seeking injunctions or declarations of unlawfulness are excluded. Actually, there is no limitation to the size of awards that can be granted. The Commission has adopted a proposal on establishing a **framework for managing financial responsibility linked to ISDS tribunals established by international agreements to which the EU is party**.[35] The default position is that the

[31] See the analysis of Bram Akkermans and Eveline Ramaekers, *Article 345 TFEU (ex Article 295 EC), its meaning and interpretations,* European Law Journal, Vol.16, No.3, 2010, p.292-314.
[32] Joined cases C-105/12 to C-107/12 *Essent*, Judgment of the Court (Grand Chamber) of 22 October 2013.
[33] See Section 6 of the consolidated CETA text as of September 2014.
[34] See Article X.21 (Procedural and other requirements for the submission of a claim to arbitration) of the consolidated CETA text as of September 2014.
[35] Brussels, 21.6.2012, COM (2012) 335 final, 2012/0163 (COD).

Member State will act as the respondent in any investment claim, especially where the claim arose from measures not adopted by the EU institutions, which is the case for healthcare services (on the basis of the primary law allocation for healthcare services enshrined in Article 168 § 7 TFEU). In the CETA, it is explicitly mentioned that "***where the measures identified in the notice are exclusively measures of a Member State of the European Union, the Member State shall be the respondent***".[36]

d. Investment tribunals are composed ad hoc and are usually comprised of three arbitrators, usually members of international law firms, retired diplomats or academics, id est **arbitrators do not have the personal independence of judges. The criteria for their appointment are imbued in ambiguity and are deficient in democratic legitimacy**.[37]

e. The proceedings and the outcome of the case are **confidential**, unless otherwise agreed. In the CETA, there are some 'fair trail' provisions on but procedural fairness has not been incorporated to a significant extent and arbitrators are left to decide upon the particulars of these rules.

f. In ISDS, there is **no appellate mechanism**. For instance, in the CETA no reference is made to an Appellate Body.

36. Given the wide spectrum and broad wording of the substantive provisions of agreements like the TTIP or CETA, any national regulatory measure may be caught by the treaty articles and be considered, depending on the context, to constitute e.g. indirect expropriation. The regulatory autonomy of national governments may be, thus, severely constrained. At this point and by way of illustration, it is also important to underscore that in the CETA the right to regulate is not unequivocally affirmed as a substantive right, leaving national governments exposed to financial liability to a foreign investor. In this regard, any new decision-making process modifying the legal and business environment as at the time the investment treaty was initially concluded may be considered to constitute a violation of the fair and equitable treatment, running counter to the principles enshrined in the TTIP and capable of triggering investment claims.

CASE LAW ON ISDS

37. There are three telling examples of challenges, as part of ISDS, to national and administrative measures taken in furtherance of health protection programs. The first two have to do with the Slovakian health insurance system. In both cases, Achmea B.V., the local

[36] See Article X.20. in Section 6 (Investor-State Dispute Settlement) of the consolidated CETA text as of September 2014.
[37] See for a discussion, Claire Cutler, *Private Power and Global Authority: Transnational Merchant Law in the Global Political Economy,* CUP, 2003, pp. 183, pointing out that "*the expansion of privatized dispute settlement through private, delocalised and transnationalized international commercial arbitration is part of a corporate strategy to further disembed commercial law and practice from the "public" sphere and to reembed them in the "private" sphere free from democratic and social control".* See, also, Barnali Choudhury, *Recapturing Public Power: Is Investment Arbitration´s Engagement of the Public Interest Contributing to the Democratic Deficit?,* Vand J Transnat´L, 2008, 41, 775 and Susan D. Franck, *The legitimacy crisis in investment treaty arbitration: privatizing public international law through inconsistent decisions,* Fordham Law Review, 2005, 73, 1521

subsidiary of which operated in Slovakia as a private insurance company, submitted a claim to arbitration against the Slovak Republic under the investment treaty between the Netherlands and the (previously) Czech and Slovak Federal Republic. The complaints had to do with the fact that albeit before 2007 the compulsory health insurance scheme in Slovakia resorted to a significant extent to the private sector, providing for a semi-public system, the new government in 2007 decided to repatriate powers and competencies to the public sector. The objective of the national legislature in 2007 was to restore the public, compulsory health insurance scheme in Slovakia and the previously private capital and insurance companies which were allowed to distribute their profits in the form of dividends had to become non-for-profit entities. Achmea B.V. was awarded in 2012 €22 million by an UNCITRAL tribunal for Slovakia's failure to abide by the investment rules.

38. Subsequently, Achmea B.V. filed an additional arbitration in February 2013 following the Slovakian's public declaration of intent to launch a single-payer health insurance market, to the exclusion of a multitude of health insurance providers. Achmea B.V. argued that although expropriation had not already taken place, the investment treaty had already been violated because customers were unlikely to take out insurance with a company that they expected to cease to exist. Further to this, Achmea B.V. contented that the general instability of the regulatory environment in health insurance harmed its business. Although eventually in May 2014 the investment tribunal rejected jurisdiction on the basis that it was not empowered to interfere with the ongoing democratic processes of a sovereign state, the pending procedures until the actual delivery of the decision resulted in the stagnation of the pertinent decision-making process and the governmental plans to create a single state health insurer were postponed until 2015.

39. On a different case, but by the same token, Eureko, a private insurance company which was subsequently merged into Achmea, won arbitration awards against Poland in 2005 and in 2007. It had operated a large part of the Polish public health and old-age insurance system and it claimed compensation through arbitration under the Netherlands-Poland investment protection treaty for the failure of Poland to further privatise its health insurance scheme.

40. The aforementioned cases illustrate how exposed the national legislature is, in the case where, initially, an amalgamation of public and private sector predominates in the delivery of healthcare and/or health insurance and, subsequently, a repatriation of powers to the public sector is envisaged. The politically sensitive character of healthcare and health insurance activities, a domain where it is settled that market forces may not predominate due to moral hazards and market failures, does not suffice for the purposes of sheltering them from the deregulatory effect of an investment treaty and ISDS. Thus to avoid unintended consequences, precise and carefully worded derogations in said treaties and investment protection systems need to be designated, paying due regard to the specificities of each individual healthcare system and the extent to which market forces participate. Given that in the CETA and TTIP, both the EU as an international organization and the Member States individually may submit their reservations, commitments and derogations, it is of immense importance that such provisos are drafted with precision by the Member States.

CARVING OUT THE NHS - HORIZONTALLY AS A (CORE) PUBLIC SERVICE

41. Free trade and investment agreements contain a number of provisions that may be relied upon in order to exempt social welfare services, ranging from services pertaining to the exercise of public authority and from core welfare services, such as social assistance schemes and health insurance systems, to services procured by public utilities in the form of state monopolies and/or hybrid undertakings.

42. Social welfare services that are and that are not economic, remunerated, public, private, provided by undertakings with profit-oriented status, all seem to be compressed under the notion of public services. At the same time, within the context of trade and investment agreements, the default position is that they include any service in any sector having an effect on trade, unless otherwise provided for. There is no convergence on a unitary notion of public services, which are bound to vary over time and between countries.

43. The available options for accommodating the operation of public services may include *horizontal* exception clauses as well as *sector-specific* exception clauses, mostly included in Annexes. In the case of horizontal exception clauses, which are inserted *in the main text of the respective agreement,* a distinction is made between services supplied in the exercise of governmental authority (public services *stricto sensu*) and public services *lato sensu*. When a public service befits the notion of a service supplied in the exercise of governmental authority, it is usually entirely exonerated from the material scope of the agreement (complete carve-out); whereas public services *lato sensu* are usually subject to the entirety of the investment treaty obligations, save for the market access discipline. Overall, said clauses can be characterized as opaque and unable to depict obligations and commitments in a transparent manner.

Services supplied in the exercise of governmental authority

44. A classic example of a horizontal, total and unconditional exception clause is Article I:3 (b) of the GATS concerning "services supplied in the exercise of governmental authority".[38] This latter notion of governmental authority is further analysed in Article I:3 (c) of the GATS as "any service which is supplied neither on a commercial basis, nor in competition with one or more service suppliers".[39] Both the expressions "on a commercial basis" and "in competition with one or more service suppliers" have given rise to considerable controversy,[40] given that there are no definitional benchmarks.

[38] It is noteworthy that in the corpus of GATS, no reference to "public services" as such is made whatsoever.

[39] The same limitation, i.e. that said activities must not be conducted in competition applies to the complete carve-out for "activities forming part of a statutory system of social security" established in Para. 1(b) of the GATS Annex on Financial Services. It is worth mentioning that, although the ILO Convention 102 of 1952 lists medical care as one of the social security branches, it is doubtful whether the notion "statutory system of social security" befits the NHS of the UK, which is financed by taxation and not by ear-marked social insurance contributions. See, also, on this point, Rudolf Adlung, *Trade in healthcare and health insurance services: The GATS as a supporting actor (?),* WTO Staff Working Paper ERSD-2009-15, pp. 8.

[40] For an overview, see, *inter alios*, Amedeo Arena, *The GATS notion of public services as an instance of intergovernmental agnosticism: comparative insights from EU Supranational Dialectic",* Journal of World Trade, 45, no.3 (2011): 489-528 and Rudolf Adlung, *Public Services and the GATS*, WTO Working Paper, July 2005, available at http://www.wto.org/english/res_e/reser_e/ersd200503_e.htm.

45. It has been suggested that the expression "on a commercial basis" is associated with profit-seeking activities, whereas in so far as the expression "in competition with one or more service suppliers" is concerned, it has been opined that the pertinent criteria[41] could be the co-existence of governmental and private services, the demand-side substitutability of said services as well as the notion of "one-way competition", whereby a service is supplied in competition only if the providers concerned act proactively, rivaling for customers.

46. Overall, and given that the exception of governmental authority in the GATS is narrowly construed so as to merely include core governmental functions,[42] it is evident that the vast majority of public services, including healthcare, lie outside the scope of the governmental authority exception.

47. Furthermore, if one wishes to transplant the *dicta* of the CJEU to the present narrative, it is worth mentioning that the CJEU seems to address healthcare provision and insurance activities as dissociable from the official authority doctrine.[43] At the same time, it is opined that within the context of EU Law, "*where the State has reserved to itself a statutory monopoly for carrying on an activity, which means that no effective competition can arise, the possibility nonetheless remains that it is acting as an operator on the market, as the existence of such a monopoly will not change the nature of the activity in question*".[44]

NHS services supplied in the exercise of governmental authority

48. At a national level, the NHS could serve as a very illuminating paradigm of the aforementioned acknowledgement. In so far as the "commercial basis" prerequisite found in the GATS is concerned, and, more specifically, if one adopts the criterion of the profit-orientation of said activities, following the establishment of the NHS Foundation Trusts, it may be substantiated that the NHS is engaged, to a significant extent, in commercial activities. *Although NHS Foundation Trusts do not have an explicit incentive to make profit, they may nonetheless raise capital from both the public and private sectors and retain proceeds from asset sales as well as financial surpluses for future investment*; after all, the motive to *save* and *accumulate* money found in non-profit making organizations may have the same effect as the pressure to *make* money found in for-profit ones.[45]

49. At the same time, the motive to save and accumulate money contradicts the principle of redistribution, as a means of financing public health schemes, and rather appertains to the principle of capitalization. The principle of capitalization entails that benefits are funded from reserves, rather than from current health insurance contributions, and as a criterion in

[41] See Rudolf Adlung, *Public Services and the GATS* , op.cit., pp. 9 et seq.
[42] Council for Trade in Services, Report of the Meeting Held on 14 October 1998, S/C/M/30, para. 22 (b).
[43] In the case of *Wouters* (C-209/99), the CJEU held that the professional regulatory body of the Bar of the Netherlands was engaged in an economic activity, because it neither fulfilled a social function based on the principle of solidarity nor did it exercise powers typical of a public authority.
[44] See the Opinion of Advocate General Maduro in the CJEU case of C-205/03P *Fenin* [2006] ECR I-6205.
[45] See Gareth Davies, *The process and side effects of harmonisation of European Welfare States,* Jean Monnet Working Paper, 2/2006, pp.24.

the case-law of the CJEU, it always indicates that the health insurance scheme at stake is engaged in economic activities and is considered to be a private undertaking.[46]

50. Next and with regard to the feature of "competition with one or more service suppliers", a précis of the operational principles of the internal market of the NHS would be self-explanatory: Following the 1990 National Health Service and Community Care Act, an internal market for healthcare was established along with a purchaser/provider split under the oversight of the Department of Health. Within the context of this purchaser/provider split, the principal NHS commissioners purchase healthcare services from NHS healthcare providers, namely GPs, dentists, pharmacists, primary-care clinics, secondary-care Hospitals *as well as from the private sector. This has become more significant as a result of the Health and Social Care Act 2012 and the introduction of "Any Qualified Provider"*.

51. Broadly speaking, *supply* side competition for the UK's public healthcare system has been introduced between providers in a twofold way:
    a. Competition *in* the market: Public and private providers compete with the aim of attracting patients and of securing that State resources are allocated to them (following the establishment of the "Payment by Result"). Actually, this competition is quite proactive and for instance hospitals actually promote their services, if one also considers that the Department of Health has from 2008 onwards relaxed the rules on advertising by hospitals.
    b. Competition *for* the market: Competition for the right to provide a particular service to patients in circumstances where a commissioner may choose one or a limited number of providers via competitive tendering. Following the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulation 2013, NHS commissioners are able to contract with an NHS Trust for a service for which there are potential private sector providers, only after a competition in which those private sector providers will have the chance to tender.

52. In the academic literature, it is opined[47] on the basis of an institutional criterion, which follows the public/private divide, that within the framework of a Beveridgian healthcare system like the traditional NHS, only if some particular services are provided by private operators *in certain situations of need and for very specific treatments*, should economic rules not be applicable to care provided by public providers. Nonetheless, things would be reversed if private provision is shown to constitute a significant part of the system and private providers effectively compete with the public ones[48] and it would be unacceptable to exclude state care from economic rules and, thereby, give economic advantages to the public providers. This is arguably the situation now for the NHS in England.

[46] See cases C-244/94 *FFSA* [1995] ECR I-4013, C-67/96 *Albany International BV v. Stichting Bedfifsenioenfonds Textielindustrie* [1999] ECR I-5751, C-155/97 *Brentjens* [1999] ECR I-6025, C-219/97 *Drinjevende Bokken* [1999] ECR I-6121 and C-437/09 *AG2R Prévoyance* [2011] ECR I-973.

[47] See, *inter alios*, Gareth Davies, *Welfare as a service,* Legal Issues of Economic Integration, 2002, 29, pp.37.

[48] See, in this regard, the Opinion of Advocate General Maduro in the CJEU case of C-205/03P *Fenin* [2006] ECR I-6205, arguing that the principle of social solidarity does not augur well with (even partial) private provision of healthcare.

53. At the same time, it is argued,[49] on the basis of the *Höfner*[50] line of case-law of the CJEU, that three positive, cumulative features of economic activity (i.e. excluding governmental authority) emerge: offering goods or services on a given market, bearing the financial risk from the enterprise and the potential to make profit. With regard to the first criterion, the CJEU has already classified the services procured by the NHS as remunerated.[51] Furthermore, if one takes into consideration the "Unsustainable Provider Process" for NHS (Foundation) Trusts which are assessed as clinically or financially unsustainable, it seems that NHS providers indeed bear the risk from the enterprise. Finally, NHS Foundation Trusts, albeit non-profit-s*eeking*, do have the *potential* to make profits. Given the above acknowledgements, NHS providers are engaged in economic activities, making any possible resort to the notion of governmental authority redundant.

54. Equally, this public/private institutional balance in the NHS has also been portrayed in the case-law; it is important to refer to the 2002 case of ***Bettercare Group LtD v. Director General of Fair Trading***.[52] In 2001, the British Office of Fair Trading had received complaints on behalf of Bettercare, a private undertaking running private care homes, that the North & West Belfast Health and Social Services Trust, its main customer, was abusing its dominant position, by imposing unfair terms. It was contented that the local NHS Trust, as well as purchasing care for the elderly from private operators such as Bettercare, it also provided its own care directly. Actually, 30% of care was delivered by the NHS Trust and, characteristically, the potential residents were presented with the choice between the NHS Trust and Bettercare´s homes in the form of a brochure as to which home they should choose.

55. The British Competition Appeal Tribunal held that

> "…*although the funding which North & West provides has a social purpose, the way in which North & West carries out or delivers its functions is by using business methods. Thus, looking at the matter from the point of view of Bettercare and other independent providers dealing with HSS trusts, NHS trusts, and local authorities, the independent providers are entering into commercial transactions. As a matter of policy North & West fulfils its statutory responsibilities through those commercial transactions, and does so on a very wide scale as, we assume, do similar bodies in Northern Ireland and elsewhere in the United Kingdom. The purpose of this system is, as we understand it, to widen choice, obtain improved and more cost-effective services, and encourage competition between providers... In our view* ***the contracts in question take place within a business setting and are as much commercial transactions from North & West's point of view as they are from the point of view of the independent providers*** [emphasis added]".

56. On the basis of the above, it is, thus, inferred that the exception stipulated in the GATS for governmental authority services is not applicable in the case of the NHS. This is of immense importance given that in the CETA the same definition for "activities carried out in the exercise of governmental authority" is adopted. It should also be noted that within the

[49] See Okeoghene Odudu, *The Boundaries of EC Competition Law, The scope of Art.81,* OUP, 2006, pp.26.
[50] Case C-41/90 *Höfner and Elser v. Macrotron GmbH* [1991] ECR I-1979.
[51] Case C-372/04 *Watts* [2006] ECR I-4324.
[52] Case 1006/2/01.

context of CETA, said services are only *partially* exempted from the material scope of *certain* provisions on establishment of investments[53] and, therefore, "activities carried out in the exercise of governmental authority" are not accrued the same degree of protection compared with the GATS.

57. For the purposes of the TTIP, the GATS notion of services carried out in the exercise of governmental authority shall be replicated by the notion of "non-economic services of general interest" according to the Commission´s "Reflections Paper on Services of General Interest in Bilateral FTAs (Applicable to both positive and negative lists)".[54] *Non-economic* services of general interest encompass according to the Commission an open-ended list including *inter alia* "statutory social security schemes".

58. It is important to note that, even though NHS commissioners act as local insurers with which enrolment is determined by reference to the place of residence, the notion of "statutory social security schemes" does not appertain to Beveridge-type NHS systems, like the British one, which are financed through general revenue taxes. "Statutory social security schemes" seem to refer to 1st pillar, Bismarck-type Social Insurance Models, which are funded via means-tested contributions and whereby the insurance system follows the actuarial technique. Countries operating on the basis of such systems include, *inter alia,* France and Germany.

59. This general exemption clause for "non-economic services of general interest" should be, according to proposals of the Commission, determined on the basis of the case-law of the CJEU. On the basis of this premise, it needs to be underscored that for the EU judiciary, it is the criterion of remuneration that is applicable. In this regard, the CJEU has defined health care services as remunerated activities under Article 56 TFEU, even when provided directly by public funds as benefits-in-kind, within the context of the NHS.[55]

NHS services as services of general economic interest (Public services lato sensu)

60. Services of general *economic* interest other than network industries, also referred to as "public services", for the purposes of EU Law, explicitly include healthcare services.[56] At the same time, they seem to constitute the EU counterpart of public utilities, as enshrined in the GATS and in the CETA. Both "public services" and "public utilities" are subject to the material scope of trade and investment agreements,[57] except for the market access obligation, i.e. the signatories may retain the number of suppliers of services of general interest. However, all the other core obligations, such as the principles of non-

[53] See Chapter 10 (Investment), Section 1, Article X.1 §2.
[54] Brussels, 28 February 2011, TRADE.B.1/SJD(2011).
[55] See the much-debated case of C-372/04 *Watts* [2006] ECR I-4325, concerning the NHS of the UK.
[56] See the "Reflections Paper on Services of General Interest in Bilateral FTAs (Applicable to both positive and negative lists)", *supra,* note 54, the CJEU case of C-475/99 *Ambulanz Glöckner* [2001] ECR I-8089, whereby public ambulance services were classified as services of general economic interest, in accordance with Article 106 (2) TFEU as well as the 2007 Communication of the Commission on Services of General Economic Interest, COM (2007) 725, pp.6.
[57] By the same token, according to Article 106 (2) TFEU, undertakings entrusted with the operation of services of general economic interest are in principle subject to the competition rules, unless the performance of the tasks assigned to them is obstructed in law or in fact.

discrimination, the fair and equitable treatment standard and protection against unfair expropriation apply to said public services.

61. In practice, this means that should a national government decide to entrust a publicly-funded healthcare service solely to a net of local providers and/or should it decide to repatriate powers to the public sector, that would directly violate the non-discrimination and fair and equitable principles, respectively. Therefore, classifying for the purposes of the TTIP healthcare services as "services of general interest", "public services" and/or "public utilities" would again expose them to the full gamut of the core treaty obligations, with the exception of the market access principle.

62. In the CETA, public utilities, including healthcare services, constitute an Annex II reservation of the EU for future measures. Thereby, it is established that "services considered as public utilities at a national or local level may be subject to public monopolies or to exclusive rights granted to private operators", i.e. the entirety of the investment obligations are in principle applicable to said services, except for the market access principle. It is noteworthy though that the aforementioned public utilities clause only concerns two restrictions on market access, i.e. monopolies and exclusive service providers. Other restrictions such as economic needs test, quotas, foreign equity ceilings etc are not covered and cannot be sheltered by the public utilities clause.

THE NHS AS A SECTOR-SPECIFIC AND ENLISTED COMMITMENT OR RESERVATION

63. In most trade agreements, exemptions designated for each State at the level of commitments or reservations only apply to particular investment obligations, such as non-discrimination, market access etc. Commitments are usually included in a positive list and reservations in a negative list.[58] The TTIP shall be based on both negative and positive listing; in the case of positive lists, the substantive obligations assumed under a trade and investment agreement solely apply to the services´ sectors listed, whereas in the case of negative lists, said substantive obligations apply generally, *unless* each State has enlisted in a negative list both existing and future measures which would be, otherwise, considered to be violations of the core obligations ("list it or lose it").

64. Negative lists are further distinguished between two different types of reservations:

    a. measures listed in Annex I usually entail the existing status-quo of a particular service sector and the State that has enlisted a measure may only revise said measure if such a revision does not decrease the conformity of the measure with the core treaty obligations (standstill clause). Measures listed in Annex I can only be amended in order to become more consonant with the trade agreement and if an enlisted service is re-nationalised, running counter to the core treaty obligations, such a policy reform shall be held to be problematic;

    b. measures listed in Annex II, however, enable countries to preserve and adopt in the future measures which are inconsistent with the core treaty obligations. Hence, if a

[58] See for an overview Markus Krajewski, *Public services in EU Trade and Investment Agreements*, op.cit.

State wishes to redraw the borders between the public and the private in favour of the public sector and attribute thereby further powers and competencies, the respective service sector must have been *a priori* enlisted in Annex II.

65. In order to schedule a specific services´sector, given that most sectors may include at the one end of the spectrum purely public activities and at the other end of the spectrum commercial activities, States tend to resort to the criterion of the public or private nature of the funding of said services. For instance, in positive listing States tend to enlist only e.g. privately funded healthcare services, whereas in negative lists, States tend to include services that receive public funding. It has been rightly underscored[59] that albeit this criterion seems attractive at first sight, at the same time it does not seem to capture some important aspects.

66. First, this criterion does not pay due regard to the fact that it is not always an easy task to discern the exact percentage of public or private funding within the context of a public service, like healthcare (for instance, how would user charges be assessed?) and, second, another important point seems to be missing; should one take into consideration the funding of the service per se or the funding of its supplier?[60] In that regard, even when the funding of the suppliers is predominantly public and healthcare is free at the point of delivery, the CJEU has explicitly held that the payments made by the health insurance funds to the hospitals, albeit set at a flat rate, unquestionably constitute remuneration for the hospital which receives them.[61] One can imagine that such a conclusion would be all the more applicable in cases where the funding sources of the service supplier are mixed, as in the case of the NHS Foundation Trusts, which can raise funds by treating private patients.

67. Therefore, it is arguable that healthcare services do not squarely fit within the notion of governmental authority. This again underlines the immense importance of individual Member States paying due regard to the wording of their commitments or reservations. In order to protect them, public health systems need to be explicitly carved out so far as their existing and future status quo is concerned. Against the background of negative listing, Annex II reservations enable the operation of public health systems to remain intact as well as to be redefined and/or re-nationalised. Should the sector to be shielded be confined to healthcare *services* per se, the carve-out should at least include "health care services provided via public health systems and regardless of the ways in which they are organized or financed at a national level or whether they are public or private".

68. In this respect, the EU´s Annex II reservation in the CETA, concerning health services includes "all health services which receive public funding or State support in any form, *and are therefore not considered to be privately funded* [emphasis added]". This reservation, although it sounds promising, contains an oxymoron; albeit in principle publicly supported health services are exonerated from the CETA, on the basis of a textual analysis, the ultimate criterion is whether they are privately funded, i.e. even a small proportion of private funding may suffice for the purposes of subjecting said services to the material

[59] See Markus Krajewski, *Public services in EU Trade and Investment Agreements*, op.cit., pp. 31.
[60] See Markus Krajewski, *ibid,* pp.31.
[61] C-157/99 *Smiths and Peerbooms* [2001] ECR I-5363.

scope of the Treaty. Finally, it is also noteworthy that the aforementioned reservation of the EU applies only in relation to a limited number of investment obligations, to the exclusion of the fair and equitable treatment standard and the protection against expropriatory takings, which, therefore, still apply to healthcare services.

69. For the purposes of adopting a more comprehensive approach on public health systems and in order to reflect their ongoing evolution, it would be safer for individual Member States to err on the side of caution and carve-out the NHS as such, in its capacity as a public health *system*. In this regard, the paradigm of the Annex II reservation of Germany in the CETA is illuminating. According to its exact wording, "*Germany reserves the right to adopt or maintain any measure with regard to the provision of the Social Security System of Germany, where services may be provided by different companies or entities involving competitive elements which are thus not "Services carried out exclusively in the exercise of governmental authority*"".

70. On one hand, Germany decided to carve-out its healthcare s*ystem* as such, instead of fragmenting it into services, whereas on the other hand, and given that the social insurance funds in Germany compete both internally and with the private sector, it declared that it may mix market and state forces at will.

UK's CETA Reservations for Healthcare

71. By way of contrast, in the CETA, the UK's Annex II reservations with regard to health services are poorly articulated; the UK singles out services and activities and does not address the NHS from a systemic point of view. More specifically, the categorization of health services, according to the UK, is three-fold:

    a. First, there are *medical services*, for which the only reservation explicitly made is that "establishment for doctors under the National Health Service is subject to medical manpower planning". In a few words, so far as clinical services are concerned, the UK seems to disregard the potential establishment of *providers,* in the sense of big business players and solely focuses on doctors.

    b. Next, another cluster of health services encompasses "ambulance services, residential health facilities services other than hospital services"; in those sectors, the UK reserves the right to adopt or maintain measures with respect to the *privately funded* ambulance services and residential health facilities services, other than hospital services. This actually entails, that *publicly funded* services of this kind are not shielded and that *hospital* services are explicitly declared as services subject to the full gamut of the CETA.
    c. Finally, a further category of health services is reserved; that of "health-related professional services",[62] mostly including *primary care services*. With regard to said services, the UK reserves the right to adopt in the future or maintain any measure requiring the establishment of suppliers and restricting the cross-border provision of health-related professional services by service suppliers not physically present in the

[62] Including medical and dental services, services by psychologists, midwives services, services by nurses, physiotherapists, paramedical personnel, retail sales of pharmaceuticals and of medical and orthopaedic goods etc.

territory of the UK. It is, thus, evident, that the UK in its Annex II reservations concerning health services, decided to expose *secondary care services, i.e. hospital services*, public or private, to the liberalizing effect of the CETA and not to submit any reservation whatsoever in this respect.

LEGAL POLICY RECOMMENDATIONS

72. It is inferred on the basis of the above that the competitive co-existence of public and private operators in the NHS of the UK ousts the notion of "services supplied in the exercise of governmental authority", which would be able to shield (even partly) the NHS from the deregulatory and liberalizing effect of agreements like the TTIP. At the same time, once the pendulum swings towards the direction of economic activities, to the exclusion of public authority prerogatives, it will be easier for arbitrators, within the context of ISDS, to implement the principles of fair and equitable treatment and the protection against expropriatory takings with rigidity.

73. Against the same backcloth, classifying the services procured by the NHS as mere "public services" or "public utilities" would again expose them to the rigor of the market-opening tools contained in the TTIP, with the exception of certain features of the market access principle.

74. At the same time, Annex II reservations solely exonerating publicly funded or supported health s*ervices* are unable to accommodate the existing heterogeneity in public health systems´ funding and might unexpectedly render NHS bodies subject to the substantive obligations of a trade and investment agreement. Therefore the negative listing of health services on the basis of the criterion of their *funding* would not be an effective way to protect them from the agreement.

75. In light of the above, a more universal carve-out of the NHS from the material scope of the TTIP emerges as a necessity in order to ensure that it is truly protected from the agreement. This would ideally be done on the basis of a pertinent *blanket* exception inserted in its *main text* (and not only within the context of Annex I or II). However, robust protection for the NHS could also potentially be achieved within the context of an Annex II reservation.

76. Carving out the NHS as a blanket exception in the main text of an agreement like the TTIP would be self-executing; for instance, in the CETA, there is a specifically designated Chapter on "Exceptions"[63] from the material scope of the agreement, whereby, inter alia, issues pertaining to "National Security"[64] are explicitly exempted from the entirety of the CETA provisions and, actually, National Security is perceived as a blanket exception. More specifically, it is thereby clarified that "This Agreement does not…prevent a Party from taking an action that it considers necessary to protect its essential security interests…". Such an exemption could be drawn up for public health systems.

77. For a solution within an Annex II reservation, wording would be of immense importance. An Annex II reservation for the NHS could potentially read as follows:

[63] See pp. 455 of the consolidated CETA text as of September 2014.
[64] See Article X.05. of the Chapter on "Exceptions" of the consolidated CETA text as of September 2014.

> "*The UK reserves the right to adopt or maintain any measure with regard to the organization, the funding and the provision of the National Health Service of the UK as well as with regard to the public and/or the non-for-profit character of the National Health Service of the UK, where services may be provided by different companies and/or public or private entities involving competitive elements which are thus not "Services carried out exclusively in the exercise of governmental authority"*

However, it is important to underscore that in the CETA, with regard to Annex II reservations, another parameter is added; the *type* of reservation. On the basis of the type of reservation, the obligation for which a reservation is taken is specified. For instance, a reservation such as the one mentioned above may be submitted but it also has to be explicitly mentioned what type of reservation it is, e.g. is it only confined to the national treatment obligation or does it cover the entirety of the investment obligations established in the CETA? In that regard, to be robust, an Annex II reservation in the TTIP would need to be explicitly made as to the full gamut of the free trade and investment principles enshrined in the agreement.