



# **CETA and TTIP**

**Potential impacts on health and social services**

## Executive Summary

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# Executive summary

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The paper's analysis allows EPSU to draw several conclusions on the potential impact of CETA (Comprehensive Economic and Trade Agreement) between the European Union (EU) and Canada and TTIP (Transatlantic Trade and Investment Partnership) between the EU and the United States (US) on health and social services. We summarise these below:

1. In trade agreements such as CETA and TTIP the main obligations affecting the provision of health and social services can be found in specific chapters dealing with topics such as:
  - Investment protection
  - cross-border trade in services
  - public procurement
  - subsidies
  - temporary entry of service suppliers and
  - recognition of qualifications.
2. In addition, there is a set of cross-cutting rules found in almost any trade agreement relating to the basic principles of market access and non-discrimination (national treatment, most-favoured nation (MFN)). Moreover, CETA and the latest TTIP drafts contain sharp investment protection standards, most importantly fair and equitable treatment and indirect expropriation, complementing the state-state dispute settlement procedures traditionally used in trade accords.
3. Regarding the health and social sectors, the European Communities' schedule for international GATS (General Agreement in Trade on Services) contains commitments on particular professional services (medical, dental and midwives services, nurses, physiotherapists and paramedics), health services (hospital services) and social services (convalescent and rest houses, old people's homes). However, in GATS neither of these service sectors have been fully opened since Member States made some specific reservations.
4. On a more general level, three observations regarding the core nature of these treaties can be made:
  - First, by assuming internationally binding trade commitments, the EU effectively locks in the status quo of privatisation and liberalisation already achieved in the Member States. Reversing the neoliberal reforms in order to restore equal access to health and universal coverage of social security systems becomes increasingly difficult and costly.
  - Second, the trade accords incorporate a logic of permanent cross-border liberalisation enabling increasingly higher levels of commitments even after their entering into force. They are "living agreements" pushing trade rules ever deeper into the realm of public health and social services.
  - Third, these treaties provide governments and transnational corporations with dispute settlement mechanisms extending and enforcing investors' rights. Due to the decision to also include investor-state arbitration in CETA and TTIP, alongside traditional state-state dispute settlement, investors will be granted an extremely powerful tool to assert their demands.

On a more specific level focusing on particular on trade rules and commitments enshrined in CETA and the latest TTIP drafts, the following conclusions may be drawn:

5. A close look at the schedules of commitments shows that the **reservations** introduced to protect public services, including health and social care taken out by the European Commission (EC) and Member States are limited and their particular wording contains many loopholes, occasionally rendering them virtually useless. As the reservations also mainly relate to market access, national treatment and most favoured nation provisions, other disciplines continue to apply, including the controversial investment protection standards, public procurement, domestic regulation, temporary entry or mutual recognition of qualifications. Most critically, CETA enables investors to file ISDS (Investor-to-State Dispute Settlement - now renamed Investment Court System (ICS)) claims against any services regulations regardless of the reservations made in the schedules of commitment. According to the drafts known so far, this would apply to TTIP too.
6. The two main horizontal provisions meant to protect public service regulations, the **governmental authority clause** and the **public utilities clause**, are largely insufficient, especially given the new types of trade agreements that CETA and TTIP represent. They do not exempt core regulations governing the provision of health and social services from the treaty rules. As competition between suppliers is an almost ubiquitous characteristic of the health and social sectors in the EU, this clause does not have much bearing on the economic realities in these sectors.
7. All the other prohibitions covered under the market access rules (except for public monopolies and exclusive rights) would continue to apply, such as regulations on the legal form of an enterprise, economic needs tests or other quantitative measures such as quotas. It is particularly worrying that even regulations of the statutory social security systems, including public health insurance might not be safe under CETA and TTIP. The practical consequence is that investors might challenge regulations of statutory social security systems, including public health insurers, which operate neither on a commercial basis nor in competition.
8. Likewise, the **sector specific reservations** made in the areas of health and social services are too narrow to exempt these sectors. The reservations seemingly limiting cross-border supply of services do not undo the commitments for temporary stays of health professionals, the categories of intra-corporate transferees have to be granted entry almost unchecked.
9. Rules governing their authorisation might be questioned, including qualification requirements, labour laws and potential rules on ethical recruitment. Similarly, the reservation limiting investment commitments to privately funded health and social services is undermined by the difficulty in delineating between publicly and privately funded services. Privately funded hospital, ambulance and residential health facilities services fall under the entire set of CETA's investment rules, except for the few Member States that made additional reservations.
10. Moreover, by assuming ever more **commitments on privately funded services**, the scope of the public systems gradually shrinks. The country-specific reservations taken out for privately funded social services appear critical too. Eleven EU Member States

(Belgium, Cyprus, Denmark, France, Germany, Greece, Ireland, Italy, Portugal, Spain, the UK) inserted a reservation protecting measures regarding “privately funded social services other than services relating to Convalescent and Rest Houses and Old People's Homes”. This clause amounts to a de facto liberalisation of long-term care such as residential homes for the elderly. The latest TTIP schedule contains the same problematic provision.

11. Yet, liberalising rest houses and old people's homes is inconsistent with the joint report of the European Commission and the Social Protection Committee recommending the integration of long-term care in national social protection systems. This will accelerate the impact of the commitments taken back in 1994 the European Community to liberalise convalescent and rest houses as well as old people's homes in its GATS schedule of commitments.
12. Due to the insufficient reservations, the **market access rules** foreseen in CETA and TTIP might interfere with planning procedures widely applied in the health and social care sectors. This could affect, for example, economic needs tests, quota systems, price controls, rules on adequate staffing levels and requirements on the legal form of businesses limiting establishment, for instance, to non-profit enterprises.
13. Discovering the loopholes of the EU's market access reservation recalls that any of the measures limiting market access are still subject to investment protection, including those where Member States took out reservations, be it quotas, economic needs tests, rules on minimum staff levels, price controls or requirements on the legal forms of business. The continued prohibition of, for example, numerical quotas could serve to challenge healthcare planning procedures applied on federal, regional and local levels in EU Member States, thereby effectively bypassing the permissibility of economic needs tests. The UK is the only EU Member State having inserted a reservation in the EU's CETA schedule referring specifically to such planning tools.
14. Likewise, price controls aimed at containing costs of **reimbursable pharmaceuticals** could also be viewed as quantitative restrictions potentially violating the trade rules. Additionally, the market access rule prohibiting regulations on the “total number of natural persons that may be employed” or “who are necessary” for performing economic activities may impair efforts to establish adequate staffing levels in health and social services. Regulations defining the minimum number of staff per bed or resident in hospitals and care homes could be interpreted as numerical quotas forbidden under the treaty.
15. The CETA rule prohibiting regulations restricting or requiring “specific types of legal entity” may prove equally problematic, since some Member States do indeed prescribe certain legal forms of business in their health sectors, while others may wish to introduce such regulations in the future. However, in this respect, only two Member States included specific reservations: France and Germany. Hospital requirement plans which are regularly updated by Germany's regional governments might also come under pressure. Moreover, it should be noted that economic needs tests (across all levels of government, including sub-central levels of provinces or municipalities) have also become the source of legal disputes in the EU (e.g. in Austria).

16. According to CETA's **public procurement** chapter while health and social services are excluded as such, public contracting entities ranging from hospitals to care homes must organise transatlantic tenders once purchases of goods, services and works surpass specific thresholds fixed in the agreement. Due to the inclusion of construction services, this also relates to the often extremely costly public private partnerships (PPPs) used for hospital construction.
17. Backtracking from these procurement commitments or even modifying PPP contracts, e.g. to reign in their often disproportionate costs, may lead to trade disputes when foreign investors involved in such contracts see their profits affected. With TTIP such risks could increase even further as the European Commission wants to include specific rules on PPPs and the scope of the public procurement chapter may be wider than in CETA. Comparing CETA with the new EU Procurement Directive shows that the latter grants contracting entities greater flexibility to bind the award of public contracts to compliance with social criteria such as collective agreements. CETA's procurement chapter does not contain any comparable reference to social standards, let alone collective agreements. Quite to the contrary. The relevant CETA provision (...) simply mentions two award selection criteria: "(a) the most advantageous tender; or (b) where price is the sole criterion, the lowest price", contrary to article 67.2 on "contract award criteria" of Directive 2014/24 that relates to award criteria enabling the "best price-quality ratio".
18. It remains a matter of dispute whether or not the "most advantageous tender" in CETA could also include social criteria such as the compliance with collective agreements. The lack of binding social, labour and other quality standards in the trade agreements' procurement chapters exposes contracting authorities to the risk of costly trade disputes. This risk cannot be underestimated given the numerous complaints of private providers to the public healthcare systems over alleged violations of national or European procurement law (e.g. in the United Kingdom and in Germany).
19. EU Member States (e.g. Poland, and Slovakia) already faced a raft of legal disputes over interventions in the **health insurance** markets enabled by ambiguities in EU law. Such conflicts could now also occur in the broader context of CETA and TTIP. There is considerable legal uncertainty as to which private health contracts constitute "a partial or complete alternative" to public health insurance. This lack of clarity already triggered several conflicts over Member State interventions in the private health insurance markets, notably in Belgium, France, Germany, Ireland, the Netherlands and Slovenia.
20. Private health insurance has evolved into an important pillar of the statutory social security system in several EU Member States, such as the Netherlands, France, Ireland, Slovenia and others. private insurers frequently challenged risk equalisation schemes requiring financial transfers from insurers with lower risk profiles to those with higher risks. The objective of risk equalisation, which is widely applied in public health insurance systems in the EU, is to lower insurers' incentive to admit only persons with lower health risks. The Netherlands, Ireland and Slovenia are among the countries which have been sued over these schemes.
21. The agreements' financial services chapters stipulate that once a party allows its own private insurers to provide services in the framework of the statutory social security system, this market has to be opened to insurers of the other party as well. Provisions

allowing regulations of private health insurers in order to defend the “general good” or equal access to health care, such as risk equalisation schemes, are lacking.

22. Challenges of regulations targeting private health insurers, such as equalisation schemes, could be based on TTIP’s financial services chapter, which does not include meaningful safeguards suitable to protect the “general good” or the viability of the statutory health insurance system. CETA and TTIP could hence trigger legal disputes involving Canadian or US investors, similar to the recent case brought by Dutch insurer Achmea against the Slovak Republic. The reservations inserted by the EU and Germany meant to protect the social security systems are ineffective because they do not cover the particular financial service provided by health insurers.
23. While EU law still grants some, though very limited, leeway for avoiding prior notification of **subsidies**, CETA’s notification and information requirements apply to any subsidies or state aids affecting trade. As a result, compensation payments granted to public hospitals and other support measures might come under additional scrutiny. Furthermore, private healthcare providers could invoke the investment protections, especially when governments change laws affecting state aid provision or will renegotiate contracts.
24. CETA provides transnational healthcare companies who are unhappy with state aid policies an additional avenue to enforce their demands. The EU’s new TTIP text contained virtually the same article as CETA, enabling challenges once governments alter their state aid regulations. Several health insurers already sued EU Member States claiming breaches of EU state aid rules after the adoption of new laws introducing risk equalisation schemes.
25. Regarding the **movement of health professionals**, CETA contains a chapter awarding various categories of workers temporary stays in the EU and Canada, ranging from 90 days to four and a half years. While the agreement allows to link the admission of contractual service suppliers to economic needs tests and qualification requirements, though these can still be bypassed, intra-corporate transferees (covering specialists, senior personnel and trainees) may enter and stay almost unchecked. Their authorisation may neither be conditioned upon specific caps of posted persons nor on particular qualification requirements. As the chapter lacks any meaningful social clauses, labour laws ranging from minimum wages to non-discrimination could be challenged.
26. CETA’s rules on posting of employees relate to the equally flawed EU Directive on Intra-Corporate Transferees (ICT), adopted in 2014. Yet, it contains several loopholes enabling a circumvention of the requirement to ensure equal treatment of workers in host and home countries. Future efforts to plug the holes of EU law could be challenged as ‘undue’ impairments of trade. Labour laws have effectively been subordinated to trade liberalisation. This could also affect ethical recruitment practices aimed at preventing recruitment from countries facing shortages of medical personnel.
27. CETA’s chapter on **mutual recognition of qualifications** prohibits “disguised restrictions on trade” and provides a framework for the negotiation of Mutual Recognition Agreements (MRA). Recognition under an MRA may not be conditioned upon any form of residency requirement, effectively banning obligations to acquire additional qualifications in the host country needed to ensure health and safety at the workplace and patient safety or to have adequate language proficiency in the language of the host country.

MRAs can and should be concluded outside trade agreements. Currently, the EU itself has no MRA with a third country in place. However, the 2008 MRA between Québec and France, which also covers health professions, is viewed as a reference for further MRAs under CETA. Moreover, the Commission already mentioned health professions among those groups potentially negotiating MRAs under TTIP.

28. Regarding **patient mobility**, regulations on the reimbursement of treatment costs incurred abroad could trigger trade disputes both under CETA and TTIP. The EU's CETA reservation on statutory social security systems might be questioned as a potential violation of the GATS agreement where the Community already liberalised consumption abroad in medical, dental and hospital services. EU citizens could therefore claim that reimbursement of treatment costs incurred in Canada cannot be refused, regardless of the EU's social security reservation in CETA. Similarly, the social security reservation included in the EU's latest TTIP schedule affords no effective protection as it is limited to social services, thereby opening the door to disputes over reimbursement of health services consumed in the US.
29. CETA and the latest TTIP draft contain Annex I reservations on the **privatisation** of state enterprises in the health, social and education sectors. It is therefore important to also assess how CETA and TTIP might affect future privatisation processes as well as potential attempts to undo past privatisations or to nationalise private providers. When selling stakes of such entities EU Member States reserve the right to impose limits on foreign ownership. However, this reservation does not cover equity sales of private providers affiliated to the statutory social security systems.
30. EU governments may not intervene when private non-profit sickness funds affiliated to the statutory system decide to sell equity stakes to commercial Canadian or US health insurers. The same applies to private non-profit hospitals run by churches or welfare organisations and operating under the statutory health system, which may decide to sell their stakes. Moreover, as it is an Annex I reservation subject to the ratchet provision, it only applies to existing measures. Hence, introducing new regulations limiting foreign ownership could violate the trade treaties.
31. Regarding reversals of privatisations, only Germany introduced a clause reserving the right to nationalise "key privately funded hospitals" (no specific provision introduced by the EU). But given that the investment protections continue to apply, investors in a hospital due to be nationalised could still invoke the prohibition of expropriation. Governments newly voted in might also be sued – in the context of CETA and TTIP – when backtracking from a privatisation pursued by their predecessors, as evidenced by an investment dispute between Dutch health insurer Eureko and Poland.







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