



CETA and TTIP

Potential impacts on health and social services

Working Paper

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1 Introduction

Over the last decades, health and social services have gradually been drawn into the realms of bilateral and multilateral trade agreements negotiated by the European Union. This process is set to continue with CETA (Comprehensive Economic and Trade Agreement) and TTIP (Transatlantic Trade and Investment Partnership), the two bilateral trade agreements the EU currently negotiates with Canada and the United States respectively. On a plurilateral level, the talks on the Trade in Services Agreement TiSA held among a group of 22 parties, including the EU, are also expected to extend market openings in the health and social services sectors.

These trade agreements complement an ongoing process of liberalisation and privatisation of the healthcare and social security systems pursued across the EU. The neoliberal reforms, either implemented autonomously by national governments or pushed by the EU, are eroding the public nature of healthcare and social security dominant in the post-war era. While intended to cut costs and to provide business opportunities, these reforms deepen social inequalities and degrade working conditions, compounded by the austerity policies implemented since the outbreak of the financial crisis. The policy of deliberate underfunding jeopardises equal access to health and social services as well as the universal coverage of social security systems. Workers in the health and social sectors suffer from a mix of low pay, overwork and precarity.¹

Instead of overcoming notorious underfunding through public investment, financed preferably by progressive taxation of income and wealth, the EU and many Member States squeeze public spending on health and social services even further. They hope to realise additional savings by fostering competition, outsourcing, privatisations, public-private partnerships, wage depression as well as the individualisation of risks through private insurance.²

Trade agreements appear instrumental in their strategy as they increase competitive pressures, exercised mainly by transnational corporations, allegedly creating better services at lower price. However, the current generation of trade agreements, having shifted their focus from cutting tariffs to eliminating non-tariff barriers (i.e. regulation), risks burdening the public purses even further. As will be shown on the following pages, the rigged rules governing treaties such as CETA and TTIP systematically favour private profit over public welfare interests.

The focus of this working paper will be on the two more advanced transatlantic trade agreements CETA and TTIP. In case of CETA, the EU published a legally revised text in February 2016 which is due to be submitted to the European Council and the European Parliament for ratification.³ Regarding TTIP, the EU published drafts of the services and

¹ For an overview see: Hermann, Christoph, 2010: The marketisation of health care in Europe. In: Socialist Register 2010: Morbid Symptoms, Volume 46, 2010, pages 125-144. On corporate interests in the long-term care sector see: Lethbridge, Jane, 2013: Care home versus home care? Which direction for care services in Europe?, PSIRU, January 2013

² Thomson, Sarah, et al., 2014: Economic Crisis, health systems and health in Europe: impact and implications for policy, World Health Organisation, European Observatory on Health Systems and Policies, Policy Summary 12. For a case study on the UK's National Health Service see: Lethbridge, Jane, 2012: Empty Promises: The impact of outsourcing on the delivery of NHS services, UNISON, February 2012

³ Comprehensive Economic and Trade Agreement (CETA) between Canada, of the one part, and the European Union [and its Member States ...], of the other part, published on 29 February 2016, http://trade.ec.europa.eu/doclib/docs/2016/february/tradoc_154329.pdf

investment chapters in July 2015⁴ as well as a revised version of the investment chapter in November 2015.⁵ These documents provide the main basis for the analysis presented here.

2 Trade rules and commitments: locking in liberalisation

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, cross-border trade in services, government procurement, subsidies, temporary entry of service suppliers and recognition of qualifications. 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). 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 (see Box 1).

Box 1

Cross-cutting rules governing trade and investment in CETA and TTIP

Market access: This rule prohibits several market access requirements, particularly quantitative measures limiting the number of foreign enterprises, the value of an investment, the quantity of output, the extent of foreign capital participation or the number of employees. It bans specific tools such as numerical quotas, monopolies, exclusive rights and economic needs tests. Prescribing a particular legal form of an enterprise is also generally forbidden.

Non-discrimination (national treatment, most-favoured nation): The non-discrimination principle of national treatment requires governments to treat suppliers or investors from the other party to a trade agreement no less favourably than domestic ones in like situations. This applies in principle also to subsidies and other kinds of public support. Similarly, the most-favoured nation principles stipulates equal treatment of all third country suppliers in like situations.

Fair and equitable treatment (FET): This is the most invoked standard in international investment disputes requiring governments not to breach investors' 'legitimate expectation' to a stable business environment. This rule tends to put governments in a regulatory straitjacket inducing them to avoid regulatory changes diminishing private profits.

Expropriation: This is the second most important investment protection standard prohibiting direct and indirect expropriations without compensation. While direct expropriation relates to seizures of private property such as nationalisations, indirect expropriation refers to public regulations limiting investors' ability to profit from their property. Similar to FET, the indirect expropriation standard in particular may have a potentially chilling effect on regulation.

⁴ European Union 2015: Transatlantic Trade and Investment Partnership, Trade in Services, Investment and E-commerce, Brussels, 31 July 2015: http://trade.ec.europa.eu/doclib/docs/2015/july/tradoc_153669.pdf.

See also the TTIP services and investment offer of the European Union: http://trade.ec.europa.eu/doclib/docs/2015/july/tradoc_153670.pdf

⁵ Transatlantic Trade and Investment Partnership: Trade in Services, Investment and E-Commerce, Chapter II – Investment, published 12 November 2015; http://trade.ec.europa.eu/doclib/docs/2015/november/tradoc_153955.pdf

Dispute Settlement: CETA and the TTIP draft provide two main avenues for settling disputes under the agreements: 1.) a ‘state-state’ dispute settlement procedure which can only be initiated by official representatives of either side of the trade agreement; 2.) an ‘investor-state’ dispute settlement (ISDS) procedure granting foreign investors the exclusive privilege to bypass national courts and sue governments before international tribunals. ISDS enables, for instance, private service providers with investment links to Canada or the United States to demand damages in case of regulatory changes diminishing their profits.

However, governments may limit the extent to which the market access and national treatment obligations actually apply to specific service sectors or state measures. These kinds of reservations are contained in so-called ‘**schedules of commitments**’ annexed to the trade agreements. In EU trade agreements, the schedules comprise both reservations made by the EU as a whole as well as reservations taken out by individual Member States.

The schedules of commitments negotiated under CETA and TTIP build on the commitments the parties already assumed in the WTO’s **General Agreement on Trade in Services (GATS)**, which entered into force in January 1995. Regarding the health and social sectors, the European Communities’ GATS schedule 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, neither of these service sectors have been fully opened since Member States made some specific reservations.⁶

In CETA and the latest TTIP draft the EU schedules have been split into specific annexes. While Annex I assembles reservations for current measures, Annex II relates to future measures. Annex II reservations are supposed to provide policy space by allowing governments to modify regulations in the future. By contrast, Annex I reservations merely protect a regulatory status quo, if at all.⁷

Moreover, Annex I contains the controversial **ratchet clause** which goes beyond a mere standstill provision by also locking in any future liberalisations occurring in EU Member States. The latest TTIP draft, e.g., stipulates that amending a measure listed under Annex I is only permitted “to the extent that the amendment does not decrease the conformity of the measure” with core treaty obligations.⁸ The same clause has also been introduced into the CETA text.⁹ This provision actually functions like a one-way street allowing only amendments that are more ‘liberal’ and prohibiting those perceived as a restriction of trade.

A cursory glance at the schedules of commitments might nevertheless lead to the impression that the European Commission and national governments have taken out many reservations suitable to protect public services, including health and social care. However, a closer look reveals that the coverage of the reservations is rather limited and their particular wording contains many loopholes, occasionally rendering them virtually useless.

⁶ European Communities and their Member States, Schedule of Specific Commitments, General Agreement on Trade in Services, GATS/SC/31, 15 April 1994

⁷ CETA text published on 29 February 2016, pages 43 (investment) and 77 (cross-border trade in services)

⁸ European Union 2015: Transatlantic Trade and Investment Partnership, Trade in Services, Investment and E-commerce, Brussels, 31 July 2015, Chapter II Investment, Article 2-7.1(c)

⁹ CETA text published on 29 February 2016, page 51

As the reservations mainly refer to the market access, national treatment and most favoured nation provisions, other disciplines continue to apply, including the most controversial investment protection standards, public procurement, domestic regulation, temporary entry or mutual recognition of qualifications.

Most critically, CETA enables investors to file ISDS 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. The headnotes introducing the schedules of commitments list those articles whose application may be restricted by the reservations.¹⁰ But tellingly the most important investment provisions relating to ISDS, fair and equitable treatment and expropriation do not show up in this list.¹¹ Investors may hence launch investment arbitration proceedings against any services regulations as long as they base their claims on alleged breaches of the FET standard or the prohibition of (direct or indirect) expropriation.

3 Governmental authority and public utilities: clauses with narrow scope

EU trade agreements usually contain two specific provisions ostensibly aimed at protecting regulation and provision of public services: the governmental authority clause and the public utilities clause. However, the wording of both provisions renders them largely unsuitable to achieve the alleged objective.

The **governmental authority clause** has been introduced into CETA's chapters on cross-border trade in services and investment. In the services chapter it reads: "This Chapter does not apply to a measure affecting: (a) services supplied in the exercise of governmental authority". However, the definition given in the chapter's Article 9.1 reveals the limited scope of this clause: "services supplied in the exercise of governmental authority means any service that is not supplied on a commercial basis, or in competition with one or more service suppliers".¹² 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.

Furthermore, since the agreement does not provide a definition of "competition", even statutory social security systems might fall under the trade rules, as the European Social Insurance Platform (ESIP) warns: "In many social security systems it is difficult to say whether services are supplied on a commercial basis or in competition with one or more services suppliers, since it is not clearly defined what is meant by the terms 'commercial basis' and 'competition'."¹³

¹⁰ In case of the CETA text published on 29 February 2016 the headnotes may be found on the following pages: headnote to Annex I: page 728; headnote to Annex II: page 1192f. In case of the EU's TTIP draft services and investment offer published 31 July 2015 the headnotes are to bound on the following pages: Annex I: page 4; Annex II: page 55, Annex III: page 117

¹¹ According to the headnotes inserted in the CETA schedules, the Parties could only take reservations limiting the application of Articles 8.4-8.8 of CETA's investment chapter, whereas Articles 8.10 (fair and equitable treatment), 8.12 (expropriation) and Section F on ISDS (Art 8.18 - Art 8.45) continue to apply. The same applies to the EU's draft TTIP offer.

¹² CETA text published on 29 February 2016, pages 74-75

¹³ ESIP 2014: Transatlantic Trade and Investment Partnership (TTIP) – Position of the European Social Insurance Platform (ESIP), 20 November 2014, page 4

In case of CETA's investment chapter, the governmental authority clause proves to be even more restricted. Article 8.2.2 reads: "With respect to the establishment or acquisition of a covered investment, Sections B and C do not apply to a measure relating to ... (b) activities carried out in the exercise of governmental authority."¹⁴ The wording opens a dangerous loophole because the chapter's sharpest investment provisions belong to Section D (fair and equitable treatment, indirect expropriation) and Section F (resolution of investment disputes between investors and states). The practical consequence is that investors could even challenge regulations of statutory social security systems, including public health insurers, which operate neither on a commercial basis nor in competition (see also Chapter 7).

A look at the **public utilities clause** reveals similar deficiencies. It features in Annex II of CETA's EU schedule of commitments as well as in the draft TTIP schedule. In CETA it reads: "In all Member States of the EU 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".¹⁵

But the reservation contains several loopholes. First, it refers only to some of the market access rules, not to the equally important obligations to ensure non-discrimination (particularly national treatment) and investment protection. Second, it excludes only a small part of the prohibited regulations affecting market access, i.e. public monopolies and exclusive rights. All the other prohibitions covered under the market access rule would continue to apply, such as regulations on the legal form of an enterprise, economic needs tests or other quantitative measures such as quotas.

4 Reservations for health and social services: limited coverage

To gain an adequate overview of the trade agreements' potential risks the sector specific reservations made in the areas of health and social services also have to be taken into account. In CETA and the recent TTIP draft the EU introduced specific reservations limiting the applicability of selected provisions on cross-border trade in services and investment.

1) Cross-border trade in services: In its CETA schedule (and similar also in the TTIP draft), the EU introduced reservations restricting cross-border trade in health and social services. According to these provisions, the EU "reserves the right to adopt or maintain any measure requiring the establishment or physical presence" of service providers and "restricting the cross-border supply" of health and social services.¹⁶

Similarly, for services supplied by health professionals such as "medical doctors, dentists, midwives, nurses, physiotherapists, paramedics, and psychologists" the EU (with the exception of Belgium, Finland, the Netherlands and Sweden) reserves the right to require residency.¹⁷

However, regarding residency, Member States made specific commitments allowing different categories of health professionals **temporary stay** in the EU of up to four and a half years. These commitments pose several risks because the categories of intra-corporate transferees have to be granted entry almost unchecked, while requirements for the

¹⁴ CETA text published on 29 February 2016, pages 41-42

¹⁵ Ibid, page 1294

¹⁶ CETA text published on 29 February 2016, page 1305

¹⁷ Ibid, page 1307

authorisation of contractual service suppliers may be challenged, including qualification requirements, labour laws and potential rules on ethical recruitment (see Chapter 9).

2) Investment: The EU’s CETA schedule also contains a reservation limiting the application of some of the agreement’s investment provisions in the health sector. It says that the “EU reserves the right to adopt or maintain any measure with regard to the supply of all health services which receive public funding or State support in any form, and are therefore not considered to be privately funded.”¹⁸ A similar clause relates to social services. However, there is considerable legal uncertainty about the delineation of publicly and privately funded services so that the benefit of this provision appears rather questionable (see Box 2).

On private funding, the reservation stipulates that the EU reserves any measures “with regard to all privately funded health services, other than privately funded hospital, ambulance, and residential health facilities services other than hospital services”. As a consequence, **privately funded hospital, ambulance and residential health facilities services** fall under the entire set of CETA’s investment rules, unless Member States made additional reservations, what only a few actually did.

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.”¹⁹ 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.²⁰

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.²¹ However, it should be born in mind that back in 1994 the European Community already committed to liberalise convalescent and rest houses as well as old people’s homes in its GATS schedule of commitments.²²

Box 2:

Ambiguous: the distinction between publicly and privately funded services

The EU’s clause on health and social services “which receive public funding or State support in any form, and are therefore not considered to be privately funded” involves at least three problems.

1.) The reservation does not determine the proportion of public financing required to qualify as a publicly funded service. Skeptics therefore assume that “even a small proportion of

¹⁸ Ibid, page 1306
¹⁹ See, for instance, Belgium’s reservation: CETA text published on 29 February 2016, page 1321.
²⁰ See: European Union 2015: Transatlantic Trade and Investment Partnership, Services and Investment Offer of the European Union, 31 July 2015, p. 90.
²¹ European Union 2014: Adequate social protection for long-term care needs in an aging society – Report jointly prepared by the Social Protection Committee and the European Commission, Luxembourg 2014
²² European Communities and their Member States, Schedule of Specific Commitments, General Agreement on Trade in Services, GATS/SC/31, 15 April 1994

private funding may suffice for the purposes of subjecting said services to the material scope of the Treaty”.²³

2.) The reservation relates to services, not the institutions providing said services. As a consequence, fee-based services supplied by public institutions may be considered as privately funded, although provided by public entities. This could, for instance, affect public health insurers funded through private contributions by employees and employers.

3.) The EU’s approach of ostensibly preserving publicly funded services while committing ever more privately funded services gradually restricts the depth and scope of the public health system. Bit by bit universal coverage and equal access to high quality treatments and care will be undermined. By binding the expanding sector of privately financed health in the trade agreements, Member States compromise their policy space. Future attempts to reverse course and increase the publicly funded share of the health system may be rejected as treaty violations.

5 Market access: circumventing planning tools

Transnational healthcare providers may use the trade agreements’ market access rules to circumvent the planning tools which are widely applied in EU healthcare systems. Although intended to protect precisely these tools, the reservations Member States inserted into the schedules of commitments could prove to be insufficient.

The EU’s CETA schedule for instance contains the following reservation supposed to limit the market access rules in the case of health services: “The participation of private operators in the privately funded health network may be subject to concession on a non-discriminatory basis. An economic needs test may apply. Main criteria: number of and impact on existing establishments, transport infrastructure, population density, geographic spread, and creation of new employment.”²⁴ The EU’s latest draft TTIP schedule has a very similar reservation.²⁵

The problem is that this reservation only limits the application of one out of several market access rules enshrined in the trade agreements: the prohibition of economic needs tests. Considering both the public utilities clause (see Chapter 3) and this sector specific reservation we may now conclude that three market access rules do not apply to health services: the prohibition of monopolies, exclusive rights granted to private operators and economic needs tests. However, the treaties’ market access provision is far broader. It also prohibits other quantitative measures such as “quotas”, limitations on “the participation of foreign capital” as well as regulations restricting or requiring “specific types of legal entity” (see Box 3). As these prohibitions are not covered by the EU’s reservations, they continue to apply.

²³ Raptapoulou, Kyriaki-Korina, 2015: The legal implications for the NHS of Transatlantic Trade and Investment Partnership, commissioned by UNITE, pp. 19-20.

²⁴ CETA text published on 29 February 2016, page 1306. In this context, the notion of ‘concession’ appears to be used in the more broader sense of an officially approved authorisation to provide health or social services, and not in the somewhat narrower sense of a concession contract awarded to private service providers under specific terms and with a fixed duration.

²⁵ Transatlantic Trade and Investment Partnership, Trade in Services, Investment and E-commerce, Brussels, 31 July 2015, Annex III, p. 155

Discovering the loopholes of the EU's market access reservations

According to the EU's schedule of commitments, three market access rules of the CETA agreement do not apply to health services: the prohibition of monopolies, exclusive rights and economic needs tests. In order to discover those prohibitions which continue to apply, it is necessary to have a closer look at the respective treaty provision. We therefore quote Article 8.4 of CETA's investment chapter in its entirety and highlight those prohibitions which are not covered by the EU's market access reservations (see below).

As can be seen, apart from the prohibitions concerning "participation of foreign capital"²⁶ and "specific types of legal entity or joint venture", the continued validity of the prohibition of quotas is of particular importance as it applies to four specific instances: "the number of enterprises", "the total value of transactions or assets", the "total number of operations or the total quantity of output" and "the total number of persons". In addition, it has to be recalled that **any of the measures limiting market access are still subject to investment protection**, including those where Member States took out reservations.

Article 8.4

Market access

1. A Party shall not adopt or maintain with respect to market access through establishment by an investor of the other Party, on the basis of its entire territory or on the basis of the territory of a national, provincial, territorial, regional or local level of government, a measure that:

(a) imposes limitations on:

(i) the number of enterprises that may carry out a specific economic activity whether in the form of **numerical quotas**, monopolies, exclusive suppliers or the requirement of an economic needs test;

(ii) the total value of transactions or assets in the form of **numerical quotas** or the requirement of an economic needs test;

(iii) the total number of operations or the total quantity of output expressed in terms of designated numerical units in the form of quotas or the requirement of an economic needs test;

(iv) **the participation of foreign capital in terms of maximum percentage limit on foreign shareholding or the total value of individual or aggregate foreign investment; or**

(v) the total number of natural persons that may be employed in a particular sector or that an enterprise may employ and who are necessary for, and directly related to, the performance of economic activity in the form of **numerical quotas** or the requirement of an economic needs test; or

(b) **restricts or requires specific types of legal entity or joint venture through which an enterprise may carry out an economic activity.**

²⁶ The EU introduced another reservation in Annex I of its CETA schedule concerning privatisation of state enterprises providing health, social or education services which may enable limitations of foreign capital participations, though only in some particular circumstances. A more in-depth analysis of this reservation may be found in Chapter 12.

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 precondition for such challenges would be that the health planning procedures involve numerical quotas or tools which could be interpreted as quotas.

Such **quota systems** do play a role, for instance, in the admission and authorisation of health practitioners such as doctors, dentists, psychologists, midwives, nurses or paramedics whose services may be reimbursable under statutory health insurance systems. In the EU, these quotas already triggered legal disputes. For example, in 2007 the European Court of Justice ruled that Germany's quota system for psychotherapists wishing to practise under the statutory health insurance system breached the obligation to grant freedom of establishment.²⁷

The UK is the only EU Member State having inserted a reservation in the EU's CETA schedule referring specifically to such planning tools. It stipulates: "Establishment for doctors in the National Health Service is subject to medical manpower planning".²⁸ However, this reservation only refers to doctors, not other categories of health personnel such as nurses, psychologists, radiologists or others. In case of nurses, the UK's planning policy does actually involve quotas for non-EU applicants.²⁹

Likewise, **price controls** aimed at containing costs of reimbursable pharmaceuticals could also be viewed as quantitative restrictions potentially violating the trade rules. EU Member States usually define lists of reimbursable medicines and set the maximum prices reimbursable through external or internal reference pricing.³⁰ These measures do not only eat into profit margins, they also effectively curb the amount of medicines to be sold on European markets. Quota systems have also been used when devising price controls.

To keep costs of the statutory health systems in check, the large majority of EU Member States monitor the prescription behaviour of physicians. Some also require them to fulfil particular **prescription quotas**, i.e. to prescribe patients a specific share of cheaper, mainly generic, pharmaceuticals.³¹ Yet, transnational pharmaceutical companies could take issue with these quotas asserting breaches of the market access provisions.

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 (see Box 3) 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.

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**

²⁷ Case C-456/05, Commission versus Germany, Judgement of the Court (Third Chamber), 6 December 2007. On this and further disputes see: Gekiere, Wouter/Baeten, Rita/Palm, Willy, 2010: Free movement of services in the EU and health care. In: Elias Mossialos et al (ed.), 2010: Health Systems Governance in Europe: The Role of European Union Law and Policy, Cambridge, p. 461-508.

²⁸ CETA text published on 29 February 2016, page 1450

²⁹ <https://www.politicshome.com/news/uk/health-and-care/news/67857/jeremy-hunt-eases-restrictions-non-eu-nurses>

³⁰ http://ec.europa.eu/economy_finance/publications/economic_paper/2012/pdf/ecp_461_en.pdf

³¹ Carone, Giuseppe/Schwierz, Christoph/Xavier, Ana, (2012): Cost-containment policies in public pharmaceutical spending in the EU, European Commission (Directorate General for Economic and Financial Affairs), Economic Papers 461, Brussels 2012

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. In France, non-EU professional health providers seeking establishment may only have access through the legal forms of “société d'exercice libéral” (SEL) or “société civile professionnelle”.³²

According to Germany’s reservation, the authorisation of “rescue services” and “qualified ambulance services” may be delegated to municipalities which “are allowed to give priority to not-for-profit operators”.³³ While not directly referring to specific legal forms, it nevertheless de facto excludes those types which are reserved for purely commercial activities. Yet, apart from these two very limited cases, Member States did not include any further provisions retaining flexibility to link establishment in the health sector to the choice of specific legal forms.

Finally, it has to be kept in mind that the **investment protection standards** continue to apply regardless of the reservations taken. Thus, the attempts to keep at least some limited policy space through limitations of the market access rules could prove to be futile. The continued applicability of the investment standards enables commercial health providers to challenge virtually all measures they might consider disadvantageous, be it quotas, economic needs tests, rules on minimum staff levels, price controls or requirements on the legal forms of business.

The fair and equitable treatment (FET) standard, for instance, is regularly being invoked to challenge administrative decisions or regulatory changes affecting foreign investments. Health providers could therefore claim a breach of the FET standard when governments alter the parameters used in economic needs tests in a way which diminishes the value of their investments. The EU market access reservation meant to shield these tests would hardly prevent such a claim because it is not the measure itself being questioned but a modification of its application. Investors could interpret such a modification as a violation of their ‘legitimate expectation’ in a stable business environment.

Planning policies restricting the authorisation or procurement of specific clinical services or medical devices could also be targeted as potential treaty violations. The National Health Service (NHS), for instance, requires local NHS organisations (so-called Clinical Commissioning Groups) to set up five-year plans which also serve as a reference for NHS contracts potentially commissioned to private service providers.³⁴ As these tools critically affect the ability to sell products or services, private providers might attack any new plan deemed to diminish their business opportunities.

Hospital requirement plans which are regularly updated by Germany’s regional governments might also come under pressure. Only clinics included in the state-level hospital requirement plans are entitled to public investment finance as well as the reimbursement of treatment costs by the statutory health insurance system.³⁵ As Germany did not introduce any specific reservation protecting this important health planning tool

³² CETA text published on 29 February 2016, page 1068

³³ Ibid, page 1081

³⁴ For an overview see: <https://www.england.nhs.uk/ourwork/futurenhs/>; for a critical assessment see: <http://www.patients4nhs.org.uk/the-five-year-plan-the-proposals/>

³⁵ Busse, Reinhard/Blümel, Miriam: Germany: Health System Review 2014, WHO European Observatory on Health Systems and Policies, Health Systems in Transition, Vol. 16, No. 2, 2014.

(neither in CETA nor in the TTIP draft), modifications of hospital requirement plans might be vulnerable to trade disputes based on alleged breaches of the FET standard.

Moreover, it should be noted that **economic needs tests** have also become the source of legal disputes in the EU. In 2009, the European Court of Justice ruled that Austria’s economic needs test conditioning the authorisation of private health institutions was not appropriate to attain the stated public interest objective. The case concerned the refusal of two Austrian provinces to authorise the establishment of outpatient dental clinics which had been based on a need assessment. The Court held that Austria’s authorisation scheme was inconsistent on two grounds: first, it did not cover group practices with comparable features, and second, it did not prevent the provinces from applying different criteria for the need assessment.³⁶

Given the far-reaching investment protections of the trade agreements, it cannot be ruled out that foreign health providers already established in the EU would equally try to exploit alleged inconsistencies in the application of economic needs tests to enforce their interests. Even differering criteria for need assessments applied on the sub-central levels of provinces or municipalities could trigger trade disputes, given that these have already been challenged under EU law.

6 Procurement: enforcing competitive tendering

The government procurement rules contained in CETA, and also foreseen in TTIP (but here still under negotiation), pose particular risks for health and social services. CETA’s chapter on government procurement distinguishes a) the different contracting authorities of the EU and Canada and b) the concrete goods, services and works to be tendered. It regulates the purchases by procuring entities of the EU and its Member States, covering the federal and sub-central levels down to the level of municipalities.

The chapter’s appendices indicate the thresholds above which the procuring entities must open up their contracts to Canadian providers. The thresholds are given in terms of special drawing rights (SDRs), a currency basket used by the IMF. At present, 1 SDR is the equivalent of roughly 1.24 Euros (6 April 2016). According to the chapter’s Annex 19-1, federal authorities and ministries must issue tenders in relation to goods and services above the value of SDR130,000.³⁷ Regional and local contracting authorities as well as “bodies governed by public” have to do so above a value of SDR200,000, as stipulated in Annex 19-2.³⁸ On top of that, the threshold for all works is SDR5 million (see Box 4).

Box 4			
CETA: EU thresholds for tenders (in SDRs)			
	Goods	Services	Works
Annex 19-1 (central government entities)	130,000	130,000	5 million
Annex 19-2 (regional or local contracting authorities in	200,000	200,000	5 million

³⁶ Case C-169/07, Hartlauer Handelsgesellschaft mbH versus Wiener Landesregierung and Oberösterreichische Landesregierung, Judgment of the Court (Grand Chamber) of 10 March 2009.

³⁷ CETA text published on 29 February 2016, page 429

³⁸ Ibid, page 495

accordance with the NUTS regulation)			
Annex 19-2 (bodies governed by public law as defined by public procurement directive (incl. hospitals, social services like social insurance and day care)	200,000 Other entities: 355,000	200,000 Other entities: 355,000	5 million
Annex 19-3 (entities operating networks in accordance with the utilities directive)	400,000	400,000	5 million

The “bodies governed by public law” relate to the EU’s procurement directive and explicitly include “hospitals” and “entities providing social services (housing, social insurance, day care)”. Consequently, public hospitals or care homes are obliged to organise transatlantic tenders once their purchases surpass the SDR200,000 threshold.

The goods, services and works which have to be put out for transatlantic tender are listed in the chapter’s Annex 19-4, 19-5 and 19-6 respectively. The list of covered services in Annex 19-4 contains a broad range of activities including, inter alia, real estate and consultancy services, human resources management, software implementation, data processing, maintenance and repair, architectural and engineering services, technical testing and analysis services as well as building-cleaning and sanitation services.³⁹ However, the list does not include health and social services. Therefore, public contracting entities engaged in health and social services, ranging from hospitals to care homes, must organise transatlantic tenders when purchasing a whole raft of services, except health and social services themselves.

Annex 19-6 requiring transatlantic tenders of construction services and works concessions is equally important because it affects the different forms of **public private partnerships (PPP)** also widely used in health and social services. PPPs are mainly contracts between governments and private consortia under which companies finance, build and operate public infrastructures, e.g. hospitals or care homes, and get repaid either through user fees or regular government payments. For example, in the UK the construction of about three quarters of NHS hospitals in the past two decades has been funded through the Private Finance Initiative (PFI) where private consortia raised money on the financial markets to construct and operate hospitals, subsequently rented back to the NHS under often over-priced lease contracts. The expensive rents contribute to the current deficits faced by many NHS organisations.⁴⁰

Through CETA, and potentially also TTIP, EU Member States bind themselves to transatlantic tendering of construction contracts for hospitals, clinics and care homes. 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.

³⁹ Ibid, pages 505-506

⁴⁰ Coote, Anna/Penny, Joe 2014: The wrong medicine. A review of the impacts of NHS reforms in England, New Economics Foundation, November 2014

With TTIP such risks could increase even further as the European Commission wants to include specific rules on PPPs. A leaked Commission document reads: “The EU takes the view that public-private partnerships of a contractual nature should in principle fall within the scope of the public procurement chapter”. A dedicated PPP annex shall provide a definition of such contracts, common rules on their award as well as “information on business opportunities”, such as the sectors where the EU and the US intend to use PPPs.⁴¹

It should also be noted that the new **EU Procurement Directive** (Directive 2014/24/EU) taking effect in April 2016 is unlikely to provide relief from CETA’s procurement obligations.⁴² The fact that the Procurement Directive (through its Articles 4(d), 74, and Annex XIV) subjects public service contracts for “social and other specific services”, including health services, to a particular regime only requiring tenders above €750,000 does not invalidate the CETA obligations.

As the Procurement Directive’s particular regime relates to health and social services, which are not included in the services list of CETA’s procurement chapter, the €750,000 threshold does not apply in CETA. Thus, all services covered in the procurement chapter’s services list still have to be put out to transatlantic tender as soon as they surpass the SDR200,000 threshold (currently roughly €248,000).

Furthermore, comparing both regimes reveals that the Procurement Directive grants contracting entities more flexibility to bind the award of public contracts to compliance with **social criteria** than CETA. For instance, Article 18.2 of Directive 2014/24/EU stipulates:

“Member States shall take appropriate measures to ensure that in the performance of public contracts economic operators comply with applicable obligations in the fields of environmental, social and labour law established by Union law, national law, collective agreements or by the international environmental, social and labour law provisions listed in Annex X.”

By contrast, CETA’s procurement chapter does not contain any comparable reference to social standards, let alone collective agreements. Quite to the contrary. The procurement chapter’s Article 19.3 on “Security and General Exceptions”, for instance, lacks any reference to specific social and labour standards, apart from more general measures to protect “public morals”, “order”, “safety” and “health”. Similarly, Article 19.9 on technical specifications for public tenders enables criteria such as “quality” or “environmental characteristics”, while completely ignoring labour standards.

Justifying social procurement criteria could therefore prove challenging. For instance, arguing that the protection of “public morals” requires compliance with collective agreements appears rather far-fetched and would certainly remain subject to interpretation. Moreover, any social procurement criteria still have to comply with further obligations included in CETA’s procurement chapter. In the event of a dispute it would be examined whether such criteria are really “necessary” or whether they represent “unjustifiable discrimination” or a “disguised restriction on international trade”.

⁴¹ <https://www.reimon.net/2015/02/16/eu-us-fta-ttip-public-procurement-chapter-coverage-of-public-private-partnerships-ppp/>

⁴² See: DIRECTIVE 2014/24/EU OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL of 26 February 2014 on public procurement and repealing Directive 2004/18/EC

Another aspect where the EU's Procurement Directive deviates from CETA relates to the **award criteria** guiding the selection of bidders. In Article 67.2 on "Contract award criteria" Directive 2014/24/EU says:

"The most economically advantageous tender from the point of view of the contracting authority shall be identified on the basis of the price or cost, using a cost-effectiveness approach, such as life-cycle costing in accordance with Article 68, and may include the best price-quality ratio, which shall be assessed on the basis of criteria, including qualitative, environmental and/or social aspects, linked to the subject-matter of the public contract in question (...)."

The particular progress contained in this Article relates to the award criteria enabling 'the best price-quality ratio'. This allows contracting bodies to score a bid against their own set of criteria, which may include social and environmental aspects. By contrast, the relevant CETA provision, contained in the procurement chapter's Article 19.14.5, simply mentions two award selection criteria: "(a) the most advantageous tender; or (b) where price is the sole criterion, the lowest price".

Critically, the chapter provides no explanation on how "the most advantageous tender" might be discovered. Unlike the EU's Procurement Directive which allows the determination of the best price-quality ratio by taking into account social criteria, the respective CETA chapter leaves the notion of "most advantageous tender" open. As a consequence, 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 the health and social sectors 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. In the UK, for instance, providers to the NHS frequently direct complaints to Monitor, the national regulator for health services in England, questioning purchasing decisions of the NHS or local Clinical Commissioning Groups (CCG). Their accusations involve allegations of discriminatory treatment or anti-competitive practices such as luring patients away from private hospitals.⁴³

Similarly, in Germany various businesses active in the public healthcare sector, ranging from construction firms to clinic chains, launched complaints before the state-level Procurement Chambers ('Vergabekammern') run by the regional governments. Award criteria, such as the weight of quality versus prices, frequently feature among the complaints over procurement decisions taken by local governments or public hospitals.⁴⁴

⁴³ See, for instance, a report on recent Monitor investigations: <http://www.nhsforsale.info/database/ccg-issues/section-75-regulations.html>

⁴⁴ See, for instance, a recent case brought before the Procurement Chamber in Hesse: <http://www.kreisblatt.de/lokales/main-taunus-kreis/Verzoegerung-beim-Klinikum;art676,1549722>. Another case involves price calculations amongst bidders competing for cleaning services in a public hospital: <http://www.bundesanzeiger-verlag.de/vergabe/aktuelles/nachrichten-vergaberecht/nachrichten-detail/artikel/olg-muenchen-gesamtpreis-entscheidet-ueber-auskoemmllichkeit-eines-vol-angebotes-13788.html>

7 Health insurance: weakening social security systems

The trade agreements currently negotiated pertain to the provision of private health insurance and might therefore also affect the statutory social security systems of EU Member States. As the boundaries between private and statutory health insurance are increasingly blurred, the expansion of private insurance may contribute to the weakening of statutory systems. Allowing higher earners to choose between statutory or private insurance, as is the case in Germany, undermines the statutory health system, since it loses the higher contributions of the well-off and has to cover a disproportionate share of high risk groups.

Allowing complementary private health insurance covering services excluded from the public system might erode the scope of statutory coverage even further. The same goes with complementary private insurance covering user charges imposed in the public health system. Both types of complementary health insurance tend to marginalise low-income earners who cannot afford private insurance policies. Low-earners have to content themselves with the declining scope of health services still covered by the statutory system.

In 1992, the EU adopted the **Third Non-Life Insurance Directive** liberalising the provision of private health insurance in the single market. Insurers established in the EU enjoy the right to sell policies throughout the Union, with or without branches in the respective Member States. The directive restricts government interventions in the health insurance market. Regulations going beyond solvency requirements are only allowed where private contracts “may serve as a partial or complete alternative to health cover provided by the statutory social security system”. In these cases governments may require insurers to comply with specific legal provisions adopted to protect “the general good”. In addition, such regulatory requirements have to be “objectively necessary and in proportion to the objective pursued.”⁴⁵

However, there is considerable legal uncertainty as to which private health contracts constitute “a partial or complete alternative” to public health insurance. Likewise, there is neither an agreed definition of “the general good” nor a common understanding on what regulatory measures might be necessary or proportionate. 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.⁴⁶

These legal uncertainties are now transferred into the larger context of the trade agreements under negotiation. To assess their potential impact on health insurance, the provisions on financial services and health services have to be taken into account. In this respect, CETA’s chapter on **financial services** stipulates:

⁴⁵ COUNCIL DIRECTIVE 92/49/EEC of 18 June 1992 on the coordination of laws, regulations and administrative provisions relating to direct insurance other than life assurance and amending Directives 73/239/EEC and 88/357/EEC (third non-life insurance Directive), Article 54.1 and recital 19

⁴⁶ See: Thomson, Sarah/Mossialos, Elias, 2010: Private health insurance and the internal market. In: Elias Mossialos et al (ed.), 2010: Health Systems Governance in Europe: The Role of European Union Law and Policy, Cambridge, p. 419-460

“This Chapter does not apply to a measure adopted or maintained by a Party relating to: (a) activities or services forming part of a public retirement plan or statutory system of social security; ... except that this Chapter applies to the extent that a Party allows activities or services referred to in subparagraph (a) or (b) to be conducted by its financial institutions in competition with a public entity or a financial institution.”⁴⁷

Consequently, once a CETA party allows its own private insurers to provide services in the framework of the statutory social security system in competition with public entities or other financial institutions, this market has to be opened to insurers of the other party as well. In addition to CETA’s market access provisions, Canadian insurers also enjoy national treatment and the far-reaching investment protections including access to ISDS.

The latest TTIP draft includes similar provisions effectively awarding US health insurance companies market access, national treatment and investment protections, once EU Member States enable competition within their statutory social security systems.⁴⁸

It should be noted here that 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. In 2006, the Netherlands introduced reforms creating a government-regulated universal and compulsory health insurance system which is wholly operated by private insurers. In other Member States complementary private health insurance has gained such importance that governments themselves started to consider private insurance as a key component of their statutory systems.⁴⁹

However, regulating private health insurers affiliated to the statutory system already triggered many **legal disputes** throughout the EU. For instance, 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. Moreover, risk equalisation has not only been challenged by private insurers keen to save costs through risk selection but also by the European Commission.⁵⁰

Such disputes could also occur in the framework of the trade agreements, since neither CETA’s nor TTIP’s financial services chapters foresee any protections for regulatory interventions ensuring the viability of the statutory health insurance system. The few safeguards contained in these chapters only refer to prudential measures imposed to protect policy holders or to ensure the integrity of financial institutions and the stability of the financial system. By contrast, 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.

⁴⁷ CETA text published on 29 February 2016, page 96

⁴⁸ European Union 2015: Transatlantic Trade and Investment Partnership, Trade in Services, Investment and E-commerce, Brussels, 31 July 2015, p. 40:
http://trade.ec.europa.eu/doclib/docs/2015/july/tradoc_153669.pdf

⁴⁹ Thomson, Sarah/Mossialos, Elias, 2010: Private health insurance and the internal market. In: Elias Mossialos et al (ed.), 2010: Health Systems Governance in Europe: The Role of European Union Law and Policy, Cambridge, p. 419-460

⁵⁰ Ibid.

The schedules of commitments as well do not contain any reservations in the financial services sector protecting regulations of private health insurers affiliated to statutory social security systems. Instead, **reservations referring to statutory systems** have only been taken out in the health and social services sectors. In CETA, for instance, the EU introduced the following Annex II reservation pertaining to health and social services:

*“Sector: Health and social services
Sub-Sector: Human health services
Social services
Industry Classification: CPC 931 other than 9312, part of 93191
Type of Reservation: Market access
National treatment
Description: Cross-Border Trade in Services*

The EU, with the exception of HU, reserves the right to adopt or maintain any measure requiring the establishment or physical presence in their territory of suppliers and restricting the cross-border supply of health services from outside their territory.

The EU reserves the right to adopt or maintain any measure requiring the establishment or physical presence in their territory of suppliers and restricting the cross-border supply of social services from outside their territory, as well as with respect to activities or services forming part of a public retirement plan or statutory system of social security.”⁵¹

According to this provision, the EU reserves the right to adopt or maintain any measure “with respect to activities or services forming part of a ... statutory system of social security”. The reservation has at least two important loopholes:

1. As it relates to cross-border trade in services, it only concerns Canadian health and social care providers without investment links in the EU. It does therefore not extend to those Canadian companies established or invested in the Union.
2. Health insurance does not belong to the services covered under this reservation because the industry classification (Central Product Classification – CPC) refers to CPC 931 which only covers “human health services” such as “hospital services”. Health insurance falls either under the sub-category CPC 81291 (accident and health insurance services) or, in case of “compulsory social security services”, CPC 91310 (sickness, maternity or temporary disablement benefits).⁵²

Therefore, Canadian private health insurers established in the EU and affiliated to statutory systems are not covered by this reservation. As a result, regulations affecting these private health insurers are prone to be challenged under the trade agreement.

The same goes for Germany, the only EU Member State to introduce an additional country-specific reservation intended to preserve its social security system: “Germany reserves the right to adopt or maintain any measure with regard to the supply of the Social Security System of Germany ...”.⁵³ The reservation intends to allow German authorities to regulate investors in the health sector who want their services to be covered by the public sickness

⁵¹ CETA text published on 29 February 2016, page 1305f.

⁵² United Nations 1991: Provisional Central Product Classification, Statistical Papers, Series M No. 77, ST/ESA/STAT/SER.M/77

⁵³ CETA text published on 29 February 2016, page 1382

funds, the main pillar of Germany's statutory health insurance system. These funds provide health insurance to roughly 90 percent of the German population. But again, the decisive limitation relates to the industry classification indicated in the reservation which only mentions CPC 93 (health and social services). Yet, as **CPC 93 includes neither private nor public health insurance**, private insurers remain outside the scope of this reservation.

The EU's latest TTIP offer on services and investment is even worse. The TTIP schedule of commitments lumps together all EU and country-specific limitations concerning a services sector into one single reservation. By doing so, many details of country-specific reservations introduced in CETA get lost in TTIP. For instance, in the TTIP schedule Germany's social security reservation does not appear anymore. In addition, the EU reservation pertaining to the "statutory system of social security" only relates to social services, not health services.⁵⁴ And as in CETA, health insurance remains outside the scope of this reservation as well.

Thus, 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 before the Permanent Court of Arbitration.

Achmea filed its claim under the Bilateral Investment Treaty (BIT) between the Netherlands and Slovakia in reaction to a Slovakian law banning private health insurers from retaining profits or distributing them to their shareholders.⁵⁵ Slovakia lost this case but the government tried to avoid the payment of damages awarded to Achmea. In a bid to enforce the award, Achmea achieved another verdict by a Luxembourg court in 2013 ordering the seizure of €29.5 million of Slovakian government assets invested in Luxembourg.⁵⁶

8 State aid: scrutinising public support

The transatlantic trade agreements could also put state aids awarded to public health and social services under increased pressure. CETA's chapter on subsidies distinguishes between "subsidies", defined as government support related to trade in goods, and "government support related to trade in services".⁵⁷

The chapter includes several obligations regarding information and consultation. According to Article 7.3.1, a party to the agreement can call for **consultations** with the other party if a subsidy or "a particular instance of government support related to trade in services" adversely affects its interests. The responding party shall endeavour either to "eliminate" its support measures or to "minimise any adverse effects". Such consultation obliges governments to justify or modify specific state aids. However, no further sanctioning option is given here because this article has been excluded from CETA's dispute settlement mechanisms.⁵⁸

⁵⁴ European Union 2015: Transatlantic Trade and Investment Partnership, Services and Investment Offer of the European Union, Brussels, 31 July 2015, Reservation No. 20 – Health and Social Services, pp. 88-90

⁵⁵ Balogová, Beata, 2012: Slovakia owes Achmea millions, court rules, *The Slovak Spectator*, 17 December 2012: <http://spectator.sme.sk/c/20045559/slovakia-owes-achmea-millions-court-rules.html>

⁵⁶ Liptáková, Jana, 2013: Slovak assets seized in dispute between state and Achmea, 24 May 2013: <http://spectator.sme.sk/c/20047077/slovak-assets-seized-in-dispute-between-state-and-achmea.html>

⁵⁷ See CETA text published on 29 February 2016, page 35-37

⁵⁸ Ibid.

In addition, every two years each party has to notify the other party of “any subsidy granted or maintained within its territory” (Article 7.2.1). However, the **notification requirement** only relates to “subsidies”, i.e. state support affecting trade in goods. Regarding trade in services, a CETA party may request information on particular instances of state support which the other party “shall promptly provide” (Article 7.2.3). Unlike the consultation mechanism, the notification and information requirement is enforceable as it remains subject to CETA’s state-state dispute settlement mechanism.

CETA’s notification and information obligations appear to go beyond the **EU state aid regime** which exempts several payments provided to public services from prior notification, including a) support for non-economic Services of General Interest (SGI), b) certain compensation payments to Services of General Economic Interest (SGEI) and c) compensation payments below specific thresholds or provided in the health and social sector.⁵⁹

However, the possibilities to exempt state aid from prior notification dwindle substantially once trade and investment in the single market could be affected. On the basis of seven local support cases (three of which involving public hospitals and clinics), the European Commission in April 2015 published some guidance determining which cases need clearance through prior notification. The guidance stresses that the general prohibition of public support to individual companies “only applies to measures which can affect trade between Member States”.⁶⁰ It goes on to explain the very limited exceptions to this rule:

“However, if State support is granted to an activity which has a purely local impact, there may not be an effect on intra-EU trade, e.g. where the beneficiary supplies goods or services to a limited area within a Member State and is unlikely to attract customers from other Member States. Moreover, the measure should have no – or at most marginal – foreseeable effects on cross-border investments in the sector or the establishment of firms within the EU’s Single Market.”⁶¹

It can therefore be deduced that once public hospitals’ services supply exceeds a limited geographically area or has a mere likelihood of attracting foreign patients, support measures may be interpreted as having an effect on trade. In addition, and particularly important, whenever public support has a “foreseeable” non-marginal effect on cross-border investments or establishment it could also constitute state aid to be notified to the Commission. Thus, even the likelihood of affecting foreign investment may suffice to subject public support measures to prior Commission approval.

While the EU regime still grants some leeway for avoiding prior notification, though only very limited, CETA’s notification and information requirements apply to any subsidies or state aids affecting trade in goods or services. As a consequence, compensation payments or other forms of support might come under additional scrutiny and could also be challenged under the trade agreement’s state-state dispute settlement mechanism.

⁵⁹ Madner, Verena/Mayr, Stefan/Damjanovic, Dragana, 2015: DIE AUSWIRKUNGEN DES COMPREHENSIVE ECONOMIC AND TRADE AGREEMENT (CETA) AUF DIE RECHTLICHEN RAHMENBEDINGUNGEN FÜR DIENSTLEISTUNGEN DER DASEINSVORSORGE IN ÖSTERREICH, Studie im Auftrag von Arbeiterkammer Wien, Österreichischer Städtebund, Verband der öffentlichen Wirtschaft und Gemeinwirtschaft Österreichs, Vienna, July 2015, pp. 18-19

⁶⁰ European Commission 2015: State Aid: Commission gives guidance on local public support measures that can be granted without prior Commission approval, Press Release, IP/15/4889, Brussels, 29 April 2015

⁶¹ Ibid.

Under specific circumstances private healthcare providers could also try to base claims questioning state aids on CETA's **investment chapter**, whose Article 8.9.4, footnote 7, clarifies: "In the case of the European Union, 'subsidy' includes 'state aid' as defined in its law." However, to successfully claim a breach of CETA's investment protections certain conditions have to be met, as Article 8.9.3 points out:

" For greater certainty, a Party's decision not to issue, renew or maintain a subsidy:

(a) in the absence of any specific commitment under law or contract to issue, renew, or maintain that subsidy; or

(b) in accordance with any terms or conditions attached to the issuance, renewal or maintenance of the subsidy,

does not constitute a breach of the provisions of this Section."

According to this article, a breach of the investment provisions may be claimed when the state assumed specific commitments "under law or contract" to issue, renew or maintain a subsidy. As a consequence, once governments alter the terms for state aid provision by changing laws or renegotiating contracts, investors may claim violations of CETA's investment provisions opening the door to ISDS proceedings. Such regulatory changes are far from uncommon. When the Netherlands and Ireland adopted their new legislations introducing risk equalisation schemes (see also Chapter 7), both countries faced lawsuits launched by insurance companies claiming breaches of EU state aid rules.⁶²

Hence, CETA provides transnational healthcare companies unhappy with state aid policies an additional avenue to enforce their demands. TTIP could offer the same option, should the latest EU proposal for the investment chapter published November 2015 be realised. The EU's new TTIP text contained virtually the same article as CETA, enabling challenges once governments alter their state aid regulations.⁶³

There are already many American investors active in the EU healthcare care sectors who might be tempted to use these provisions. The world's largest health care provider, Hospital Corporation of America (HCA), for instance, is expanding in the UK.⁶⁴ North American investors, including private equity firm Blackrock, hold 31 percent of the shares in German healthcare group Fresenius. The company owns a global network of clinical services enterprises with affiliates in Europe and the US, along with the largest network of private clinics in Germany (Helios Kliniken Group).⁶⁵

9 Temporary stay of professionals: bypassing labour law

The transatlantic trade agreements under negotiation also include rules on labour migration in the health sector, covering both temporary work and permanent establishment abroad. Yet, from a social perspective, the particular challenge posed by the movement of health

⁶² See: Thomson, Sarah/Mossialos, Elias, 2010: Private health insurance and the internal market. In: Elias Mossialos et al (ed.), 2010: Health Systems Governance in Europe: The Role of European Union Law and Policy, Cambridge, p. 419-460

⁶³ See: Transatlantic Trade and Investment Partnership: Trade in Services, Investment and E-Commerce, Chapter II – Investment, published 12 November 2015, Article 2.3, page 3; http://trade.ec.europa.eu/doclib/docs/2015/november/tradoc_153955.pdf

⁶⁴ See HCA Hospitals webpage: <http://www.hcahospitals.co.uk/>

⁶⁵ Fresenius' shareholder structure: <http://www.freseniusmedicalcare.com/en/investors/shares/shareholder-structure/>

professionals is to ensure equal access to high quality care for all, in both sending and receiving countries, as well as good working conditions for domestic and migrant workers alike. Without proper regulation migrant work simply covers staff shortages in more affluent countries caused by underinvestment, low pay and harsh working conditions, while the root causes of these shortages remain untouched. Even worse, as many employers tend to use migrants to downgrade jobs and cut wages, working conditions may further aggravate.

Unfortunately, the EU regime governing movement of health professionals does little to tackle the causes of staff shortages in receiving and sending countries, which can mainly be attributed to insufficient funding aggravated by austerity policies. Instead of tackling underinvestment, the focus of EU and Member State policies remains on ‘flexibilising’ work and boosting labour mobility to balance supply and demand of healthcare personnel. This is compounded by the EU’s approach to foster temporary and circular migration, the latter referring to repetitions of short-term stays of third country nationals in the EU.⁶⁶ The same logic is now being enshrined in the trade agreements.

Under current **EU law**, the Community gained competences to regulate conditions of entry and residence for third country nationals, while Member State still retain the right to determine the volumes of admissions. Specific EU regulations on labour immigration from third countries encompass directives on highly qualified workers (the Blue Card), seasonal workers, intra-corporate transferees as well as a single work and residence permit for non-EU workers.⁶⁷ Some of these regulations have been carried over to CETA.

Apart from the rules governing market access (see Chapter 5), CETA includes specific chapters on temporary stay and the recognition of professional qualifications, the latter a precondition for both temporary service supply and permanent establishment abroad (see Chapter 10).

The chapter on “Temporary Entry and Stay of Natural Persons for Business Purposes” regulates temporary service supply in the EU and Canada for various categories of workers.⁶⁸ It shall not extend to people seeking permanent access to the labour market, as Article 10.2.2 purports. According to Articles 10.2.3 and 10.2.5, laws on temporary stay, employment and social security, including regulations concerning collective agreements or minimum wages, shall continue to apply.

However, Article 10.3.2, says that both parties “shall apply those measures so as to avoid unduly impairing or delaying trade in goods or services or conduct of investment activities”. Obviously, this clause opens large room for interpretation on what might actually constitute an ‘undue’ impairment of trade. Labour market regulations are therefore far from being protected.

The wording of Article 10.3.2 is even stronger by saying that the treaty shall not prevent parties from applying measures on temporary entry, “provided that such measures are not applied in such a manner as to nullify or impair the benefits accruing to any Party under the

⁶⁶ See: European Commission 2007: COMMUNICATION FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT, THE COUNCIL, THE EUROPEAN ECONOMIC AND SOCIAL COMMITTEE AND THE COMMITTEE OF THE REGIONS On circular migration and mobility partnerships between the European Union and third countries, COM(2007) 248 final, Brussels, 16.5.2007

⁶⁷ Stuchlik, Andrej/Poptcheva, Eva-Maria, 2015: Third-country migration and European labour markets: integrating foreigners, Briefing, European Parliamentary Research Service, July 2015

⁶⁸ CETA text published on 29 February 2016, pages 79-86.

terms of this Chapter.” Thus, the agreement exhibits a clear tendency to grant unhampered trade precedence over labour laws.

The chapter contains **various categories of workers** (key personnel, contractual service suppliers, independent professionals, short-term business visitors) enjoying different rights with regard to the permissible length of stay, ranging from 90 days to four and a half years.⁶⁹ Annexes to the chapter include reservations Member States inserted for the various categories of workers, covering mainly work permits and economic needs tests.

Two sub-categories of key personnel, **specialists and senior personnel**, enjoy the most generous conditions. Both categories are so-called intra-corporate transferees, i.e. employees or partners of a transnational corporation present in the EU and Canada and posted abroad to a branch, subsidiary or head company of that enterprise. Their permissible length of stay is fixed at “the lesser of three years or the length of the contract, with a possible extension of up to 18 months at the discretion of the Party granting the temporary entry and stay” (Article 10.7.5(a)). So, specialists and senior personnel may be transferred abroad for up to three years, with a potential extension of another one and a half years. A third category of intra-corporate transferees called **graduate trainees** may be posted abroad for training purposes for up to one year.

In addition, Article 10.7.2 prohibits host countries from limiting the number of posted specialists, senior personnel and graduate trainees: “Each Party shall not adopt or maintain limitations on the total number of key personnel of the other Party allowed temporary entry, in the form of a numerical restriction or an economic needs test.”

In Annex 10-B, a few EU Member States introduced some minor reservations limiting the far-reaching rules on key personnel. For instance, Austria, the Czech Republic, Slovakia and the UK included the very narrow reservation that “Intra-corporate transferees need to be employed by an enterprise other than a non-profit organisation”. Bulgaria requires that the number of non-EU employees in a Bulgarian enterprise may not exceed 10 percent of the workforce.⁷⁰ But what is important here is that there are no reservations whatsoever excluding any particular service sectors. Hence, the rules awarding specialists and senior personnel temporary stay of up to four and a half years almost fully apply to health professionals. In addition, unlike contractual service suppliers and independent professionals, they are not subject to any specific requirements proving their qualification.

What is more, due to the vague definitions of these categories almost any group of employees may be covered. Specialists, for example, are defined as possessing “an advanced level of expertise or knowledge of the enterprise’s products and services” (Article 10.1(c)(ii)), what may apply to almost any employee, be it nurses, doctors or managers. As a result, transatlantic health enterprises owning subsidiaries or branches on both sides of the Atlantic enjoy very generous conditions for posting employees abroad, covering periods of up to three or potentially even four and a half years.

⁶⁹ For an overview see: Fritz, Thomas, 2015: Analysis and Evaluation of the Comprehensive Economic and Trade Agreement (CETA) between the EU and Canada, study commissioned by Hans-Böckler-Foundation, Berlin, January 2015, p. 25f.

⁷⁰ CETA text published on 29 February 2016, page 346

CETA's rules on posting of employees relate to the equally flawed **EU Directive on Intra-Corporate Transferees (ICT)**, adopted in 2014.⁷¹ Similar to CETA, the ICT Directive covers three categories of workers: managers, specialists and trainees. Yet, it contains several loopholes enabling a circumvention of the requirement to ensure equal treatment of workers in host and home countries.

Due to these flaws some of the labour regulations of the sending country could become applicable to the posted employees. This allows employers to refuse transferred workers the same benefits as local workers regarding social security contributions or pay, thereby saving costs and putting workers in host countries under unfair competition.⁷² CETA does nothing to overcome these flaws as it simply refers to the continued applicability of current labour legislation, including all its shortcomings. Even worse, future efforts to plug the holes of EU law could be challenged as 'undue' impairments of trade.

In CETA slightly different rules apply to the categories of **contractual service suppliers (CSS)** and **independent professionals (IP)**, both of which persons working abroad to fulfil a services contract. While contractual services suppliers act as employees of enterprises which gained a services contract abroad without having an establishment in the respective country, independent professionals are self-employed having themselves won a services contract abroad. Under CETA, both enjoy a maximum stay of 12 months.

Unlike specialists and senior personnel, contractual service suppliers and independent professionals must possess a university degree or an equivalent qualification as well as professional experience of at least three years (CSS) or six years (IP) respectively (Article 10.8). In addition, in Annex 10-E comprising reservations concerning CSS and IP, EU Member States reserve the right to apply any measures regarding licensing and qualification requirements including specific examinations such as language tests.

The sectoral reservations in Annex 10-E show that the EU did not make any commitments for independent professionals (IP) in the health sector (the category remains 'unbound'). By contrast, contractual service suppliers (CSS) of various health professions enjoy rights to temporary stay in several Member States, though not all, provided economic needs tests do not impede their entry (see Box 5). In all three groups of health professions (medical and dental services, midwives services, nurses/physiotherapists/paramedics) Sweden comes out as the most liberal country imposing no further limitations on CSS entering for temporary stay (see the respective entry: 'In SE: None').

⁷¹ DIRECTIVE 2014/66/EU OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL of 15 May 2014 on the conditions of entry and residence of third-country nationals in the framework of an intra- corporate transfer, Official Journal of the European Union, 27.5.2014, L157, pages 1-22

⁷² See: Brieskova, Lucia, 2014: The new Directive on intra-corporate transferees: Will it enhance protection of third country nationals and ensure EU competitiveness? EU Law Analysis, 17 November 2014, <http://eulawanalysis.blogspot.de/2014/11/the-new-directive-on-intra-corporate.html>

Box 5

CETA: Temporary entry: list of reservations concerning contractual service suppliers and independent professionals in the health sector

<p>Medical (including psychologists) and dental services (CPC 9312 and part of CPC 85201)</p>	<p>CSS: In SE: None. In CY, CZ, DE, DK, EE, ES, IE, IT, LU, MT, NL, PL, PT, RO, SI: Economic needs test. In FR: Economic needs test except for psychologists, where: unbound. In AT: Unbound except for psychologists and dental services, where: Economic needs test. In BE, BG, EL, FI, HR, HU, LT, LV, SK, UK: Unbound. CAN: Unbound.</p> <p>IP: EU: Unbound. CAN: Unbound.</p>
<p>Midwives services (part of CPC 93191)</p>	<p>CSS: In SE: None. In AT, CY, CZ, DE, DK, EE, EL, ES, FR, IE, IT, LT, LV, LU, MT, NL, PL, PT, RO, SI: Economic needs test. In BE, BG, FI, HR, HU, SK, UK: Unbound. CAN: Unbound.</p> <p>IP: EU: Unbound. CAN: Unbound.</p>
<p>Services provided by nurses, physiotherapists and paramedical personnel (part of CPC 93191)</p>	<p>CSS: In SE: None. In AT, CY, CZ, DE, DK, EE, EL, ES, FR, IE, IT, LT, LV, LU, MT, NL, PL, PT, RO, SI: Economic needs test. In BE, BG, FI, HR, HU, SK, UK: Unbound. CAN: Unbound.</p> <p>IP: EU: Unbound. CAN: Unbound.</p>

However, as seen before (see Chapter 5), the reference to economic needs tests by itself may not be sufficient to protect measures regulating temporary stays of contractual service suppliers, as they could still be challenged by other market access provisions, e.g. the prohibition of numerical quotas, and the dispute settlement procedures. Furthermore, the chapter's requirement to avoid "unduly impairing or delaying" trade and investment or to not "nullify or impair the benefits" of the agreement might also put pressure on regulators.

These risks are compounded by the fact that the chapter lacks any meaningful social clause safeguarding the primacy of national labour market legislation over the treaty rules. On the contrary, **labour laws have effectively been subordinated to trade liberalisation**. Only reaffirming that labour regulations shall continue to apply, as the chapter does, cannot protect them from potential challenges alleging undue impairments of trade and investment. Therefore, national labour regulations ranging from minimum pay to non-discrimination could be subjected to additional scrutiny.

This could also affect **ethical recruitment** practices aimed at preventing recruitment from countries facing shortages of medical personnel.⁷³ For example, the EU's Blue Card Directive, establishing a fast-track procedure for issuing residence and work permits to highly qualified workers, allows for the rejection of applications "in order to ensure ethical recruitment in sectors suffering from a lack of qualified workers in the country or origin" (Article 8.4).⁷⁴

While CETA allows to link the admission of contractual service suppliers in the health sector to economic needs tests and qualification requirements, though these can still be bypassed, specialists, senior personnel and trainees may enter and stay almost unchecked. Their authorisation may be restricted neither by caps on the number of posted persons nor by particular qualification requirements. Since almost any employee could qualify as a specialist, transnational health corporations enjoy ample scope for posting as much personnel abroad as they wish.

It should be noted that the liberalisation of free movement of health professionals in EU trade agreements is a more recent phenomenon, providing further evidence of the Community's growing influence on national healthcare systems. After the coming into force of the GATS agreement in January 1995, negotiations on the free movement of service suppliers continued. During the course of these negotiations the EU extended its liberalisation commitments by inserting the category of contractual service suppliers into a supplement of its GATS schedule.

However, neither the EU's 1994 GATS schedule⁷⁵ nor the 1995 supplement⁷⁶ do contain any commitments regarding temporary entry and stay in the healthcare sector. The later inclusion of obligations on the free movement of health professionals in EU trade agreements may therefore be interpreted as a reflection not only of the growing mobility of

⁷³ See the EPSU-HOSPEEM code of conduct on Ethical Recruitment and Retention in the Hospital Sector: <http://www.epsu.org/a/3715>. Also relevant the WHO Global Code of Practice on the International Recruitment of Health Personnel: <http://www.who.int/hrh/migration/code/practice/en/>

⁷⁴ COUNCIL DIRECTIVE 2009/50/EC of 25 May 2009 on the conditions of entry and residence of third-country nationals for the purposes of highly qualified employment, Official Journal of the European Union, 18.6.2009, L155, pages 17-29

⁷⁵ European Communities and their Member States, Schedule of Specific Commitments, General Agreement on Trade in Services, GATS/SC/31, 15 April 1994

⁷⁶ European Community and its Member States, Schedule of Specific Commitments, Supplement 2, World Trade Organisation, GATS/SC/31/Suppl.2, 28 July 1995

these professionals but of the manifest commercial interest in an increasingly global healthcare business.

10 Recognition of qualifications: enforceable through sanctions

One of the EU's main pillars furthering labour migration is Directive 2005/36/EC on the recognition of professional qualifications, recently amended by Directive 2013/55/EU. The directive sets rules for temporary stay, establishment and the recognition of qualifications within the EU.⁷⁷ It provides, inter alia, automatic mutual recognition of qualifications for seven regulated professions out of a total of some 800 across the EU: doctors, nurses, dental practitioners, midwives, pharmacists, veterinary surgeons and architects.⁷⁸

Under automatic recognition, qualifications acquired in one Member State will be accepted in another one without additional assessments or training requirements. The amending Directive 2013/55/EU introduced the European Professional Card (EPC), an electronic procedure accelerating the recognition of qualifications. For the moment, it can be used for five professions including nurses responsible for general care, pharmacists and physiotherapists.⁷⁹

The health professions therefore belong to the first and rather small group of occupations which have been afforded automatic recognition of qualifications throughout the EU, a clear indication of an increasingly liberalised health labour market. Extending such recognition procedures beyond the EU belongs to the objectives of trade agreements such as CETA and TTIP.

CETA includes a specific chapter providing a framework for mutual recognition of professional qualifications and so-called **Mutual Recognition Agreements (MRA)** to be negotiated between the EU and Canada. As it does not foresee any sectoral exclusions, it also covers the health and social sectors. According to Article 11.2.2, the chapter applies to "professions which are regulated in both Parties, including in all or some EU Member States and in all or some Provinces and Territories of Canada." In case an MRA came actually into force, it would thus apply throughout the entire territory of the EU, including those Member States without specific rules on the profession in question.

Article 11.2.3 contains the regulatory straightjacket typical for trade agreements: "A Party shall not accord recognition in a manner that would constitute a means of discrimination in the application of its criteria for the authorisation, licensing or certification of a service supplier, or that would constitute a disguised restriction on trade in services." This clause is critical because it not only bans discrimination but also "**a disguised restriction on trade**", a term opening the door to broad interpretations. As follows from Article 11.2.2., this obligation applies to recognitions of qualifications awarded by the EU and its Member States as well as by Canada and Canadian provinces. It covers not only mutual but also unilateral recognitions granted by the authorities of a CETA party.

⁷⁷ http://ec.europa.eu/growth/single-market/services/free-movement-professionals/qualifications-recognition/index_en.htm

⁷⁸ <http://epthinktank.eu/2014/03/26/recognition-of-professional-qualifications-2/>

⁷⁹ http://ec.europa.eu/growth/single-market/services/free-movement-professionals/policy/european-professional-card/index_en.htm

Furthermore, the parties are obliged to encourage the relevant authorities and professional bodies to submit drafts of MRAs to a so-called “MRA Committee”, composed of representatives of the EU and Canada (Articles 11.3 and 11.5). If both parties accept the MRA, it would be adopted by that committee. It comes into force once both parties submit respective notifications. In addition, Annex 11-A provides non-binding guidelines outlining a four-step process for mutual recognition intended to facilitate the negotiation of MRAs.

Additional rules have to be observed from the moment an MRA becomes effective. According to Article 11.4.3., **recognition under an MRA may not be conditioned upon “any form of residency requirement”** or “a service supplier’s education, experience or training having been acquired in the Party’s own jurisdiction”. This appears as a potentially harmful prohibition as the acquirement of additional qualifications or experience in the host country may be justifiable on grounds of workplace safety and consumer protection, particularly in the health sector. It might also be warranted to acquire adequate language proficiency in the host country. Yet, such requirements could be banned under an MRA compliant with CETA.

Currently, the EU itself has no MRA with a third country in place. However, the **MRA between the Canadian province of Québec and France**, signed in 2008, served as an important reference for CETA’s recognition chapter. So far, about 100 professional authorities used the framework of the Québec-France agreement to negotiate individual MRAs for numerous occupations, amongst which dentists, nurses, physicians, opticians, pharmacists, physiotherapists, midwives, radiologists, dental and medical technologists as well as social workers.⁸⁰

It was the government of Quebec which, apart from business groups, has reportedly been pushing for the inclusion of the recognition chapter in CETA.⁸¹ According to the Canadian government, professional associations of architects, engineers and foresters already declared an interest in negotiating MRAs under the CETA framework.⁸²

TTIP shall also include rules on mutual recognition of qualifications, though negotiations are expected to be complicated due to the lacking harmonisation of entry requirements among US federal states. However, some occupations in the US including medicine and nursing do have a uniform national exam potentially facilitating mutual recognition.⁸³ A European Commission presentation on the topic mentions the health professions among those groups potentially negotiating future MRAs under TTIP.⁸⁴

However, as a matter of principle, it appears highly questionable to include the mutual recognition of professional qualifications into the framework of trade agreements. **MRAs can and should be concluded outside trade agreements**, as is already standard practice. Subjecting negotiations and concluded MRAs to the rules and enforcement mechanisms of trade agreements risks producing suboptimal outcomes, downgrading qualifications and

⁸⁰ <http://www.mrifce.gouv.qc.ca/en/grands-dossiers/reconnaissance-qualifications/entente-quebec-france>

⁸¹ Johnson, Pierre Marc/Muzzi, Patrick/Bastien, Véronique, 2013: The voice of Quebec in the CETA negotiations, Policy Brief, International Journal, 68(4), pages 560–567

⁸² Government of Canada 2013: Canada-European Union Comprehensive Economic and Trade Agreement: Technical Summary of Final Negotiated Outcome, Agreement-in-principle

⁸³ Sumption, Madeleine/Papademetriou, Demetrios G/Flamm, Sarah, 2013: Skilled Immigrants in the Global Economy: Prospects for International Cooperation on Recognition of Foreign Qualifications, Migration Policy Institute, Washington, December 2013

⁸⁴ Deraedt, Filip: Deepening Trade and Integration through the Mutual Recognition of Professional Qualifications: the CETA model, European Commission, Trade

jeopardising health and safety. Treating specific qualification requirements as “disguised restrictions on trade” serves to weaken regulations aimed at protecting the general good.

11 Patient mobility: reimbursement rules vulnerable

Patient mobility and the option to claim reimbursement of treatment costs incurred abroad by patients’ home country social insurance institutions continues to be a sensitive issue which already triggered several disputes in the EU. The topic raises particular concerns over deepening social inequalities regarding access to healthcare, threats to regulatory sovereignty and the financial viability of social security systems.

Under **EU law** patients covered by their home country’s statutory health insurance system have the right to receive reimbursement for treatments received in another EU Member State. Only under specific conditions may home countries require prior authorisation of treatments abroad, primarily in case of hospital treatments and highly specialised cost-intensive treatments. The authorisation may be refused when a) the treatment can be provided domestically within a medically justifiable time-limit, b) the treatment involves unacceptable risk for the patient, c) the general public will be exposed to safety risks, or d) the health provider raises concerns regarding compliance with quality standards.⁸⁵

The question is whether CETA and TTIP would prohibit EU Member States from conditioning reimbursement on prior authorisation when patients seek treatment in Canada or the United States. Could public health insurers refuse reimbursement of such treatments after the coming into force of these agreements?

Generally, CETA and the latest TTIP draft do cover services consumed abroad. The respective articles defining cross-border trade in services expressly include services supplied “in the territory of a Party to the service consumer of the other Party”.⁸⁶ In trade parlance this type of services trade is called “consumption abroad or “mode 2””.⁸⁷

Regarding reimbursement of treatment costs incurred abroad, the liberalisation commitments enshrined in the 1994 **GATS agreement** have to be taken into account. Here the EU and the United States followed very different approaches. In their GATS schedules of commitments concerning ‘hospital and other health care facilities’, the U.S. inserted the following mode 2 limitation of the national treatment rule: “Federal or state government reimbursement of medical expenses is limited to licensed, certified facilities in the United States or in a specific US state”.⁸⁸ Thus, US citizens receiving treatments in another WTO Member State may not claim reimbursement from federal or state health insurers in the US. By contrast, the then European Community did not include any such reservation in its GATS schedule.⁸⁹

⁸⁵ Baeten, Rita, 2012: Europeanization of national health systems: National impact and EU codification of the patient mobility case law, OSE/EPSU, July

⁸⁶ CETA text published on 29 February 2016, page 74; Transatlantic Trade and Investment Partnership, Trade in Services, Investment and E-commerce, Brussels, 31 July 2015, page 3

⁸⁷ This expression goes back to the four modes of services supply distinguished in GATS: mode 1: cross-border supply, mode 2: consumption abroad, mode 3: commercial presence, mode 4: presence of natural persons. See: GATS Article 1.2: https://www.wto.org/english/docs_e/legal_e/26-gats_01_e.htm

⁸⁸ See: The United States of America: Schedule of Specific Commitments, General Agreement on Trade in Services, GATS/SC/90, 15 April 1994

⁸⁹ See: Krajewski, Markus, 2010: Patient mobility beyond Calais: health services under WTO law, 30 June 2010: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1763416

However, the EU's schedule of commitments attached to CETA now contains the reservation concerning health and social services retaining regulations "with respect to activities or services forming part of a ... statutory system of social security".⁹⁰ This clause can be interpreted to also cover rules governing the reimbursement of treatments received abroad. By contrast, in the EU's latest draft TTIP schedule the social security reservation only relates to social services, not health services.⁹¹ As a consequence of this rather inconsistent scheduling approach, it appears that EU Member States could refuse reimbursement when their citizens received health treatment in Canada but not when they underwent treatment in the United States, provided CETA and the current TTIP version would come into force.

However, even the validity of the EU's **social security reservation** in CETA cannot be taken for granted given the lack of protections for reimbursement regulations in the European Community's GATS schedule of 1994. There is hence an obvious contradiction between the multilateral GATS agreement, where the European Community fully liberalised consumption abroad in medical, dental and hospital services, and the bilateral CETA agreement, where the EU inserted the social security reservation limiting the reimbursement of treatment costs incurred abroad.

Given that a) both Canada and the EU are WTO members and b) the EU did not protect reimbursement regulations in GATS, EU citizens could claim that reimbursement of treatment costs incurred in Canada cannot be refused, regardless of the EU's social security reservation in CETA. In order to strengthen their case, they could also point to CETA's Article 1.5 which clearly states: "The Parties affirm their rights and obligations with respect to each other under the WTO Agreement and other agreements to which they are party."⁹²

Patient mobility therefore raises the difficult and largely unresolved issue of the withdrawal of commitments in bilateral trade agreements which have already been made on the multilateral level. The issue has a greater relevance because it is a rather frequent phenomenon that commitments in bilateral trade agreements fall short of those made in multilateral agreements. Adlung and Miroudot, for instance, detected numerous "**GATS-minus commitments**" in regional or bilateral trade agreements.⁹³

Given this considerable legal uncertainty, it cannot be ruled out that reimbursement regulations trigger trade disputes under CETA as well as TTIP. Under CETA, the EU's social security reservation could be questioned as a potential violation of GATS commitments which the parties committed to respect. Should the last known version of the TTIP schedule be implemented, the social security reservation could not provide protection as it is limited to social services, thereby opening the door to disputes over reimbursement of health services consumed in the US.

⁹⁰ CETA text published on 29 February 2016, page 1305f.

⁹¹ European Union 2015: Transatlantic Trade and Investment Partnership, Services and Investment Offer of the European Union, Brussels, 31 July 2015, Reservation No. 20 – Health and Social Services, pp. 88-90

⁹² CETA text published on 29 February 2016, page 1305f

⁹³ Adlung, Rudolf/Miroudot, Sébastien, 2012: Poison in the wine? Tracing GATS-minus commitments in regional trade agreements, WTO Staff Working Paper, No.ERSD-2012-04

12 Privatisation and nationalisation: limiting policy space

Neoliberal healthcare reforms pursued in Europe over the last two decades not only involved commercialisation and marketisation (e.g. creation of internal markets, competition among providers, performance-oriented compensation) but also outright privatisations. These involved the transfer of assets from the public to the private sector through, for instance, compulsory tendering, public private partnerships, outsourcing and hospital sales.⁹⁴ 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.

CETA and the latest TTIP draft contain largely similar Annex I provisions related to **privatisation of state enterprises** in the health, social and education sectors. In CETA the respective provision reads:

Any Member State of the EU, when selling or disposing of its equity interests in, or the assets of, an existing state enterprise or an existing governmental entity providing health, social or education services, may prohibit or impose limitations on the ownership of such interests or assets, and on the ability of owners of such interests and assets to control any resulting enterprise, by investors of Canada or of a third country or their investments. With respect to such a sale or other disposition, any Member State of the EU may adopt or maintain any measure relating to the nationality of senior management or members of the boards of directors, as well as any measure limiting the number of suppliers.⁹⁵

The scope of this clause is limited to the privatisation of state enterprises or governmental entities, i.e. selling or disposing of equity interests in these entities. Only in such cases may the parties impose limitations on ownership, nationality of management and the number of suppliers. Consequently, these measures do not extend to private enterprises affiliated to the statutory social security systems of EU Member States, be it commercial or non-commercial ones. For example, 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.

What is more, as it is an Annex I reservation subject to standstill and ratchet, and therefore only applying to existing measures, any regulatory changes of the measures deemed to affect foreign investors may be questioned. Only changes which do “not decrease the conformity of the measure” with the trade agreements would be permissible.⁹⁶ Hence, introducing new regulations limiting foreign ownership of state enterprises due to be privatised could constitute a breach of the trade treaties.

But what about governments intending to reverse past privatisations or to nationalise private health providers? Somewhat unsurprisingly, the EU itself did not include any specific

⁹⁴ Hermann, Christoph, 2010: The marketisation of health care in Europe. In: Socialist Register 2010: Morbid Symptoms, Volume 46, 2010, pages 125-144. For an overview of transnational health corporations active in the EU see: Lethbridge, Jane, 2013: Expansion and Consolidation?, Major trends and eligibility for European Works Councils, PSIRU, January 2013

⁹⁵ CETA text published on 29 February 2016, page 908. See also the respective provision in the EU’s draft TTIP schedule: European Union 2015: Transatlantic Trade and Investment Partnership, Services and Investment Offer of the European Union, Brussels, 31 July 2015, pages 10-11

⁹⁶ CETA text published on 29 February 2016, page 51

provision protecting **nationalisations or reversals of privatisation** in the health and social sectors. However, Germany inserted a clause in Annex II of the CETA and TTIP schedules explicitly enabling the nationalisation of hospitals. In CETA it reads: “Germany reserves the right to maintain national ownership of privately funded hospitals run by the German Forces. Germany reserves the right to nationalise other key privately funded hospitals.”⁹⁷

However, Germany is the only Member State to include such a provision. And given that the investment protections continue to apply, investors in a private hospital due to be nationalised by the German government could still invoke the prohibition of expropriation or the fair and equitable treatment standard.

Backtracking from a privatisation plan could also be challenged, as did the Dutch health insurer Eureko in its case brought against Poland. In 1999, Poland allowed a consortium led by Eureko to acquire 30 percent of the shares of PZU, the Polish insurance company operating large parts of the statutory health insurance and pension system. In the share purchase agreement, the government declared its intention to float further PZU shares, which would have allowed Eureko to acquire a controlling stake. But as the planned initial public offering (IPO) was later cancelled, Eureko initiated arbitration proceedings claiming breaches of the bilateral investment treaty (BIT) between Poland and the Netherlands and demanding a compensation of about €2 billion. After winning a partial award in 2005, Eureko reached a settlement with Poland in 2009 requiring PZU to pay a special dividend of €1.8 billion to Eureko.⁹⁸

In its award issued in 2005, the tribunal found that the provisions of an addendum later attached to the share purchase agreement (SPA) “demonstrate clearly that the statement of intent which had been agreed by the parties in the SPA had now crystallized and become a firm commitment of the State Treasury”.⁹⁹ By later frustrating the floatation of further shares, Poland “breached the basic expectations of Eureko”, thereby violating the fair and equitable treatment provisions of the BIT. In addition, the tribunal ruled that the refusal to hold the IPO was “expropriatory”, since Eureko “acquired rights in respect of the holding of the IPO and that these rights are ‘assets’”.¹⁰⁰

The CETA and TTIP investment chapters include provisions enabling similar cases. For instance, Article 8.10.4 of CETA’s investment chapter says: “When applying the above 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.”¹⁰¹

Therefore, if governments create a “legitimate expectation” to continue a planned privatisation plan which is later being frustrated, e.g. after a new government was voted in, the discontinuation of the privatisation could constitute a breach of the fair and equitable treatment standard. In this way, CETA lays the basis for further claims akin to the one Eureko brought against Poland. The latest EU proposal for the TTIP investment chapter published in

⁹⁷ Ibid, page 1383. For the respective TTIP provision see: European Union 2015: Transatlantic Trade and Investment Partnership, Services and Investment Offer of the European Union, Brussels, 31 July 2015, page 90

⁹⁸ Henderson, Julie, 2009: Eureko secures exit from Polish PZU row, Investment & Pensions Europe (I&PE), 2 October 2009: <http://www.ipe.com/eureko-secures-exit-from-polish-pzu-row/32881.fullarticle>

⁹⁹ See: Eureko B.V. versus Republic of Poland, Partial Award, Brussels, 19 August 2005

¹⁰⁰ Ibid.

¹⁰¹ CETA text published on 29 February 2016, page 48

November 2015 contains the same problematic clause enshrining investors' "legitimate expectations".¹⁰²

13 Summary and conclusions

This paper's analysis allows to draw several conclusions on the potential impact of CETA and TTIP on health and social services. On a more general level, three observations regarding the core nature of these treaties have been 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 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 enforcing compliance with the trade rules. 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 trade rules and commitments enshrined in CETA and the latest TTIP drafts, the following conclusions may be drawn:

- The two main horizontal provisions meant to protect public service regulations, the **governmental authority clause** and the **public utilities clause**, are largely insufficient. They do not exempt core regulations governing the provision of health and social services from the treaty rules. It is particularly worrying that even regulations of the statutory social security systems, including public health insurance, might be challenged under CETA and TTIP.
- 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. Rules governing their authorisation might be questioned. Similarly, the reservation apparently limiting investment commitments to privately funded health and social services appears porous due to the legal uncertainty about the delineation of publicly and privately funded services. Moreover, by assuming ever more commitments on privately funded services, the scope of the public systems gradually shrinks.
- 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.
- According to CETA's **procurement** chapter, 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

¹⁰² Transatlantic Trade and Investment Partnership: Trade in Services, Investment and E-Commerce, Chapter II – Investment, published 12 November 2015, page 4

private partnerships used for hospital construction. 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.

- EU Member States 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. 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. 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.
- 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. 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.
- 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.
- 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. 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.
- 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.

- CETA and the latest TTIP draft contain Annex I reservations on the **privatisation** of state enterprises in the health, social and education sectors. 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. 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. Regarding reversals of privatisations, only Germany introduced a clause reserving the right to nationalise “key privately funded hospitals”. 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 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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