How CETA could undermine public health

Annexes to EPHA Position

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Annex 1: Policy coherence between Trade and Health (alcohol, tobacco, unhealthy food, affordable medicines)

The scale and threat of Non-Communicable Diseases (NCDs) are recognised globally by the adoption of global policy declarations, and goals and targets. As the World Health Organization (WHO)[1] points out, the United Nations High-level Political Declaration on NCDs in 2011[2] was followed by the Global Action Plan for the Prevention and Control of Non-Communicable Diseases 2013–2020 and the Global Monitoring Framework agreed at the Sixty-sixth World Health Assembly in 2013,[3] and a set of time-bound commitments agreed at the second United Nations High-Level Meeting in 2014 for reporting by 2018. Reduction of NCD-related premature mortality is also included as a specific target within the Sustainable Development Goals and within the monitoring framework of the WHO European health policy framework, Health 2020.

There is no safe level of tobacco use. Treatment of negative consequences of tobacco use costs more than 25 billion EUR/per year. Furthermore, tobacco is the most significant cause of premature deaths in the EU, responsible for almost 700,000 deaths every year.[4]

Harmful consumption of alcohol is deleterious to health. In total, the societal costs of alcohol in the EU for 2010 were an estimated €155.8 billion.[5] Alcohol is the leading risk for ill-health and premature death for the core of the working age population (25-59 years).[6] 1 out of 4 road fatalities in EU are due to alcohol; in 2010 nearly 31,000 Europeans were killed on the roads-25% of these fatalities were related to alcohol.[7] A recent OECD report from 2015 shows that alcohol negatively affects OECD countries' socioeconomic performances as productivity losses associated with harmful alcohol use are in the region of 5% of GDP in most countries.[8]

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[1] EUR/RC66/11 Action Plan for the Prevention and Control of Non-Communicable diseases in the WHO European Region http://www.euro.who.int/__data/assets/pdf_file/0011/315398/66wd11e_NCDActionPlan_160522.pdf?ua=1

[2] Resolution 66/2. Political Declaration of the High -level Meeting of the General Assembly on the Prevention and Control of Non-Communicable diseases. New York: United Nation General Assembly; 2011 A/66/2; http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/66/2

[3] Global Action Plan for the Prevention and Control of Non-Communicable Diseases 2013–2020. Geneva: World Health Organization; 2013 http://www.who.int/nmh/publications/ncd-action-plan/en/

[4] Impact assessment of the Tobacco Products Directive (2014/40/EU) http://ec.europa.eu/health/tobacco/docs/com_2012_788_ia_en.pdf

[5] Rehm, J. et all (2012) Interventions for alcohol dependence in Europe: A missed opportunity to improve public health

[6] Scientific Opinion of the Science Group of the European Alcohol and Health Forum (2011) Alcohol, Work and Productivity

[7] European Transport Safety Council (2011) 5th Road Safety PIN Report

[8] Organisation for Economic Cooperation and Development (OECD) report 'Tackling Harmful Alcohol Use: Economics and Public Health Policy', Page 28, line 16. http://www.oecd.org/els/health-systems/tackling-harmful-alcohol-use-9789264181069-en.htm

Overconsumption of certain foodstuffs, namely those high in fat, salt and sugar (HFSS) leads to overweight, obesity and a range of NCDs. The majority of the population, and one in five children, are overweight or obese in the OECD area.[9] • In 2005, the costs of obesity and overweight to the EU were estimated at €81 billion[10]

Affordable medicine prices are key cornerstone of public health policies. Trade policy should avoid maintaining the current ineffective and costly research and development (R&D) system that rewards new medicines with fixed-term monopolies (patents) and encourages unaffordable price. Instead of that, trade can contribute to the creation of an R&D system that is driven by public health needs and delivers medicines that are universally accessible and affordable.

[9] OECD Obesity Update 2014 http://www.oecd.org/els/health-systems/obesity-update.htm
[10] European Commission (2007). Impact Assessment Repot – A Strategy for Europe on Nutrition, Overweight and Obesity related health issues.

Annex 2: Elimination of tariffs relevant for health

What?	Current EU tariff	After CETA
Processed products, miscellaneous food preparations	Starts at 12.8%	0% tariff
Processed pulses and grains, including baked goods, pulse flour, meal and powder	Start at 7.7%	0% tariff
Fresh or chilled beef and veal	High quality beef: 12.8% + 176.80 EUR/100kg Current autonomous tariff-rate quota of 20%.	0.0% tariff-rate quota, with gradual phase-in of 5,140 metric tons a year up to 30,840 from Year 6 and beyond
Frozen or other beef and veal	High quality beef: 12.8% + 176.80 EUR/100kg Current autonomous tariff-rate quota of 20%.	0.0% tariff-rate quota, with gradual phase-in of 2,500 metric tons a year up to 15,000 from Year 6 and beyond
Pork	Various specific tariffs, e.g.: Fresh/frozen swine carcasses: 53.60 EUR/100kg Fresh/frozen hams: 77.80 EUR/100kg	0.0% tariff-rate quota, with gradual phase-in of 12,500 metric tons a year up to 75,000 from Year 6 and beyond

Annex 3: Why CETA is problematic for Services of General Interest

Article 14 TFEU and Protocol 26 TFEU recognise the special role of Services of General Economic Interest and the freedom of organisation of public authorities when providing Services of General Interest. These services include but are not limited to healthcare, education, social services and water supply services providing access to water and sanitation.

The Court of Justice of the European Union (CJEU) has consistently ruled that requirements related to public policies (such as public health, social security, and public housing policies) constitute overriding reasons in the public interest, thus justifying restrictions to the freedom of establishment and movement.[11] These services provided directly to the person are essential for the fulfilment of basic EU objectives, such as the achievement of social, economic and territorial cohesion, social inclusion, high levels of employment and of public health, and economic growth. [12]

The healthcare sector deserves specific attention in the context of the right to regulate and particular attention should be given to excluding healthcare systems from the different trade agreements.[13] A recent European Commission study reported that in 2010 there were around 17m jobs in the healthcare sector, which represented 8% of all jobs in the then EU-27.[14] For most EU governments, health is typically the largest area of government expenditure (around 20%[15] of the public budget after social protection and it is one of the main areas of public expenditure projected to come under additional pressure as a result of demographic ageing, increases in chronic diseases, and the widening gap in health inequalities.

As regards healthcare systems, there are no agreed indicators to measure the quality of health systems and there is no evidence that privatisation guarantees better health outcomes. However, some Member States have found that partial privatisation leads to the fragmentation of the health systems and decreases the average quality of care.

CETA is problematic for Services of General Interest because:

1. The reservation only applies fully if those social, health, education and water services are publicly funded. This has the potential to undermine universal access to those services and exacerbate the dual (public-private)

[11] See for example Case C 372/04 Watts [2006] ECR I-4325, paragraph 103, in relation to a social security system; case C-567/07, paragraph 30 and 31, about public housing policy.
[12] Social Platfrom Position Paper on Preserving Services of general Interest In Trade Agreements http://www.socialplatform.org/wp-content/uploads/2015/11/20151027_SocialPlatform_positionpaper_TTIP_TiSA_public-services.pdf
[13] EPSU working paper on CETA and TTIP: Potential impacts on health and social services, May 2016 http://www.epsu.org/article/new-epsu-working-paper-ceta-and-ttip-potential-impacts-health-and-social-services
[14] 2012 European Commission Staff Working Document on an Action Plan for the EU Health Workforce
[15] General government expenditure statistics. Data from April 2012, most recent data: Further Eurostat information.

system of service provision in the EU. Businesses are driven by a profit making logic and not by the general interest. They choose to provide services in urban and wealthy areas and invest in the most profitable sub-sectors. As SGEI are not fully excluded in an unequivocal way, CETA will increase the tendency to treat those services as commodities and to call on people to pay out of their own pocket.

2. CETA is the first EU agreement with a **'negative list'** approach for services commitments meaning that all services will be subject to market liberalisation unless an explicit exception is made. SGEI are subject to constant changes. New services in the social, health, education or water field should be treated in the same way as the services of the sector to which they belong but with negative listing in CETA, this becomes impossible.

3. Concerning the reservations made in Annex I, CETA contains a **controversial 'ratchet clause'** stipulating that a non-conforming measure (reservation) can be applied only ***"to the extent that the amendment does*** not decrease the conformity of the measure, as it existed immediately before ***the amendment,"*** [16] Thus, regulations can only be amended in a way that leads to more liberalisation and not less. With that restriction – particularly when combined with the possibility for private companies to sue European governments under the investor protection provisions – this represents a legal obstacle to returning privatised services to state operation.

These findings run contrary to the declaratory statements in the CETA Interpretive Declaration that 'CETA does not prevent governments from regulating the provision of these services in the public interest' as commitments made now could have a binding effect on future governments.

[16] Article 8.15 (c) Reservations and exceptions 1. Articles 8.4 through 8.8 do not apply to: (p 51) http://ow.ly/Qcz0304DUfg