

# How CETA could undermine public health

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european public health alliance





## Summary

EPHA calls on Members of Parliaments to reject the recently negotiated agreement between EU and Canada, known as a Comprehensive Economic and Trade Agreement (CETA)<sup>1</sup>, and in particular the Investor Protection Provisions (Investment Court System-ICS proposed).

The Court of Justice of the European Union (CJEU) should be requested to provide an Opinion on the legal compatibility with the ICS provisions with European Union law, before ratification, to avoid costly legal challenges with uncertain outcomes after entry into force.

The European Commission should undertake an urgent assessment of the potential impacts of removal of tariffs on health-harmful products on public health, so that national governments can make plans for mitigating measures and policies.

The European Commission should undertake an urgent assessment of the potential impacts on the price of medicines, as a result of closer regulatory cooperation with Canada – a country with the second highest per capita medicines spend in the world, second only to the USA.

## Why is EPHA calling for the rejection of CETA?

Under CETA foreign investors will be able to claim compensation for public policy measures, including health protection, which frustrate their investment expectations. While ICS is not necessary in a trade deal between mature economies with established rule of law and mature domestic court systems, investment protection provisions have already been systematically exploited by companies acting against the public health interest – for example, the numerous cases brought by tobacco companies with the intention of preventing, delaying or blocking public health legislation.

CETA is the first trade agreement between the EU and a major world economy and the most far-reaching bilateral trade agreement negotiated to date. However, CETA should be interpreted in the context of ever-more expensive medicines causing reduced access to healthcare and the high and growing burden of chronic non-communicable diseases (NCDs), such as cardiovascular disease (CVD), diabetes, cancers, chronic respiratory diseases as well as obesity, as these constitute the largest health burden in the EU and Canada.

**Chronic diseases represent the major share of the burden of disease in Europe** and are responsible for 86% of all deaths<sup>2</sup> and 70 to 80% of health care budgets. An estimated € 700 billion per year is spent on chronic diseases in the European Union.<sup>3</sup> NCDs will lead to the loss of 5% of global GDP, equivalent to \$47 trillion, according to estimates.<sup>4</sup> **Two thirds of premature deaths** in the WHO European Region, at least 80% of all heart disease, stroke

<sup>1</sup> <http://ec.europa.eu/trade/policy/in-focus/ceta/>

<sup>2</sup> [http://www.euro.who.int/\\_data/assets/pdf\\_file/0008/96632/E93736.pdf](http://www.euro.who.int/_data/assets/pdf_file/0008/96632/E93736.pdf)

<sup>3</sup> The 2012 Ageing Report: Economic and budgetary projections for the 27 EU Member States (2010-2060), European Economy 2/2012, European Commission.

[http://ec.europa.eu/economy\\_finance/publications/european\\_economy/2012/pdf/ee-2012-2\\_en.pdf](http://ec.europa.eu/economy_finance/publications/european_economy/2012/pdf/ee-2012-2_en.pdf)

<sup>4</sup> Bloom, David et al. (2011), 'The Global Economic Burden of Non-Communicable Diseases', World Economic Forum, Geneva, [http://www3.weforum.org/docs/WEF\\_Harvard\\_HE\\_GlobalEconomicBurdenNonCommunicableDiseases\\_2011.pdf](http://www3.weforum.org/docs/WEF_Harvard_HE_GlobalEconomicBurdenNonCommunicableDiseases_2011.pdf)



and diabetes and 40% of cancer **could be prevented**.<sup>5</sup> 60% of the NCD burden is due to common risk factors, notably tobacco, poor diet, alcohol, environmental factors and lack of physical activity. **Tobacco, foodstuffs and alcohol are widely traded goods.**

While trade liberalisation initiated in CETA has the potential to support public health by supporting economic growth, higher incomes and greater employment opportunities, this can be undermined by the unintended side-effects of the trade deal. **Sustainable growth cannot be achieved without addressing the NCD burden and this should be reflected in trade policy.** CETA is incoherent with key public health policy goals and does not contribute to the battle against the growing burden of NCDs and obesity, and does not contribute to universal access to affordable medicines.

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

1. Revised investment protection measures will not stop tobacco, alcohol, unhealthy food companies and private investors in public services from challenging public health laws

The biggest concern of the public health community is the impact of the revised CETA Investment Court System rules on public health policy making. The preamble and article 8.9 are supposed to strengthen the protection of the right to regulate which is key for improving public health.

#### ***“Article 8.9 Investment and regulatory measures***

***For the purpose of this Chapter, the Parties reaffirm their right to regulate within their territories to achieve legitimate policy objectives, such as the protection of public health, safety, the environment or public morals, social or consumer protection or the promotion and protection of cultural diversity.***

***For greater certainty, the mere fact that a Party regulates, including through a modification to its laws, in a manner which negatively affects an investment or interferes with an investor's expectations, including its expectations of profits, does not amount to a breach of an obligation under this Section.”***

Lifesaving measures which can be affected by this clause include among other initiatives, **plain packaging of tobacco, minimum unit pricing of alcohol and traffic-light food labelling.** Any new national initiatives in these areas to protect public health are very likely

<sup>5</sup> 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](http://www.euro.who.int/_data/assets/pdf_file/0011/315398/66wd11e_NCDActionPlan_160522.pdf?ua=1)



to be challenged in international arbitration once CETA is in force, as proposals for such laws are systematically subject to arbitration and other forms of legal challenges by the tobacco<sup>6</sup>, alcohol<sup>7</sup> and processed food<sup>8</sup> industries. Whilst domestic courts and the CJEU have often found in favour of governments seeking to protect health, an international arbitration process would pose a further major delay to public health protection measures in practice *and more importantly* is intended to dissuade governments from considering such policies – the ‘regulatory chill’ effect.

While Article 8.9 does reaffirm the right to regulate to achieve public health policy objectives, contrary to public statements of the EU and Canada, **this is only a declaration and not a legally enforceable measure**. It merely reiterates what is already the case under the existing investment protection regime: that governments have the ‘right to regulate’ but must compensate investors in situations where this infringes on their substantive investment rights. This can have a ‘chilling effect’ on regulation without legally undermining the right of governments to enact particular measures. The public health community has witnessed the chilling effect of legal challenges already brought by the tobacco industry.

**Given the current wording of the substantive investment protection standards (including, notably, on indirect expropriation and the incredibly broad ‘fair and equitable treatment’), investment protection measures could potentially be used to challenge government decisions concerning reversal of liberalisation of services for the public interest relevant for health (social, healthcare, education and water).**

The North American Free Trade Agreement (NAFTA) between the USA, Mexico and Canada includes ISDS. Chapter 11 provides for investment arbitration where it is alleged that one of the contracting parties has breached its NAFTA investment obligations. Of the three contracting states, Canada has been sued the most 35 times in total (compared to 22 claims against Mexico and 20 against the US), which accounts for 45% of investment arbitration that has taken place under Chapter 11. In those 35 cases, Canada has lost or settled 6 claims, and accordingly, it has paid over \$170 million in damages. Additionally, in the other 29 cases that it did not settle or it won, it is estimated that Canada has spent \$65 million in legal defence. Many of the legal challenges that Canada has faced under NAFTA have included investors’ protestations that domestic legislation introduced by the Canadian government to enhance environmental protection e.g. Ethyl Corp (1997) where the US challenged a Canadian ban on import and export of a gasoline additive (a suspected neurotoxin). The US company challenged the ban. Canada chose to settle the case and offered \$13 million in damages and consequently repealed the ban.<sup>9</sup>

Thus, ISDS can and has led to regulatory chill and weaker environmental and health protections. The ICS mechanism proposed in CETA will not necessarily prevent such cases and outcomes.<sup>10</sup>

<sup>6</sup> Phillip Morris vs Australia <http://www.mccabecentre.org/focus-areas/tobacco/philip-morris-asia-challenge> or Phillip Morris vs Uruguay [http://www.tobaccotactics.org/index.php/Philip\\_Morris\\_vs\\_the\\_Government\\_of\\_Uruguay](http://www.tobaccotactics.org/index.php/Philip_Morris_vs_the_Government_of_Uruguay)

<sup>7</sup> Scotch Whisky Association (SWA) against the Scottish Minimum Unit Pricing (MUP) <http://www.bbc.com/news/uk-scotland-35160396>

<sup>8</sup> Producers complaining about the Finnish Tax on Chocolate and Sweets <http://www.loc.gov/law/foreign-news/article/finland-tax-on-chocolate-and-sweets-to-be-eliminated-2017/>

<sup>9</sup> <http://www.international.gc.ca/trade-agreements-accords-commerciaux/topics-domaines/disp-diff/gov.aspx?lang=eng>

<sup>10</sup> [http://www.huffingtonpost.ca/2015/01/14/canada-sued-investor-state-dispute-ccpa\\_n\\_6471460.html](http://www.huffingtonpost.ca/2015/01/14/canada-sued-investor-state-dispute-ccpa_n_6471460.html)



According to our **detailed, legal analysis of the ICS CETA text**<sup>11</sup> undertaken together with a coalition of public interest civil society organisations (BEUC, Transport & Environment, ClientEarth and the European Environmental Bureau), despite some improvements, fundamental concerns have not been addressed in the revised CETA investment chapter. Other shortcomings include:

1. **A parallel Investment Court System is not necessary between the EU and Canada, as both are trading blocs with stable democracies, mature established Court systems and legislature.**
2. **The policy space to protect and improve public health may be compromised.**
3. **The principle of exhaustion of domestic remedies is not included in CETA.**
4. **Integrity and independence of future judges is still questionable.**
5. **There is legal uncertainty that the CETA ICS is compatible with the EU law.** We therefore ask the European Parliament to request an ECJ Opinion ahead of ratification to verify the compatibility, to avoid costly legal wrangling after entry into force.

## 2. Tariff eliminations on unhealthy processed food and drinks and on agricultural products could contribute to the NCD and obesity epidemics

By eliminating tariffs on unhealthy food and beverages and meat, without taking into account the health and social costs, **CETA could increase their availability** and therefore **could contribute to the NCD and obesity epidemic in Europe**. Increased affordability will have negative impacts in terms of cancers, heart disease and strokes, respiratory diseases, type 2 diabetes and addiction which are already at levels which significantly reduce the **productivity of the European workforce**, incur a massive – and avoidable – chunk of health service expenditure and already threaten the **sustainability of our health systems and services**.

Canada's annual exports of processed foods and beverages into the EU between 2011 and 2013 averaged \$913.3 million.<sup>12</sup> CETA will remove 99% of customs duties on goods originating in the EU/Canada either when CETA comes into force or gradually over a period of 3- 7 years. **Almost all existing tariffs on processed foods and beverages will be eliminated immediately** when CETA enters into force. Reduction in tariffs could lead to **a further decrease in prices** of processed foods, high in energy, saturated fats, trans-fats, sugar, salt and refined carbohydrates, which in turn could lead to their **increased consumption**. **Several studies found that food products for which consumers are especially responsive to price changes are:** Sugar-sweetened beverages, foods eaten

<sup>11</sup> 'Joint Analysis of CETA's Investment Court System (ICS) prioritising Private Investment over Public Interest' and 'Annex1:Legal analysis of CETA's Investment Court System(ICS)' available at <http://epha.org/do-revised-investment-protection-rules-in-the-eu-canada-trade-deal-make-any-difference/>

<sup>12</sup> Global Affairs Canada (2014). Canada-European Union: Comprehensive Economic and Trade Agreement (CETA).



away from home, meats and processed foods. For these food groups higher prices were associated with significantly lower consumption.<sup>13 14 15</sup>

Tariff reduction will have a knock on impact on public health, the burden of disease and costs to health services. However, EPHA does not advocate maintaining or increasing tariffs. Whilst tariffs currently do offer some protective effect for public health – they are not designed nor intended to do so. In order to make sure those negative health impacts of tariff removal can be headed off, or minimized, the potential impacts need to be properly assessed, so that governments will be able to take policy action to offset or mitigate the health impacts. A health impact assessment of the removal of tariffs has not yet been undertaken.

This example makes clear that the right of governments to regulate how they see fit is essential and must not be compromised by trade deals. As it stands that right to regulate would be undermined by CETA, in particular by the investment protection provisions - a double blow for public health.

### 3. CETA ignores the health risks linked to high meat consumption by making market access commitments

OECD data shows that **meat consumption is considerably higher in both the EU and Canada**.<sup>16</sup> European citizens on average eat **40% more saturated fat** than recommended by the World Health Organisation (WHO), with animal products representing **80% of intake**.<sup>17</sup> While EEA data suggest some decreasing amount of beef and pork consumption<sup>18</sup>, increased beef and pork trade between the EU and Canada could exacerbate the situation, and could contribute to reverse the trend by adding additional market pressure.

Currently agricultural products are covered by an **average tariff rate of 13%**. The European Union will eliminate 92.2% of its agricultural tariffs at entry force into CETA, after 7 years 93.8% will be eliminated. A few sensitive agriculture products receive special treatment or have been excluded from liberalisation commitments. Beef, pork and canned sweet-corn have been offered as tariff rate quotas. Chicken and turkey meat, eggs and egg products have been excluded from tariff reductions altogether.

Although the EU maintains considerably higher tariffs on sensitive agricultural products, substantial concessions were made in the beef and pork sector in exchange for increased access to Canada's cheese market. Canada will receive immediate duty free access for 50,000 tons of beef which will be divided into a quota for frozen beef (15,000 tons) and fresh chilled beef (35,000 tons). The EU will also eliminate the in-quota of 20% duty on

<sup>13</sup> Andreyeva, Tatiana (2010). The Impact of Food Prices on Consumption: A systematic Review of Research on the Price Elasticity of Demand for Food

<sup>14</sup> Lisa M. Powell et Al. (2013). Assessing the Potential Effectiveness of Food and Beverage Taxes and Subsidies for Improving Public Health : A Systematic Review of Prices, Demand and Body Weight Outcomes

<sup>15</sup> Andreyeva, Tatiana (2010). The Impact of Food Prices on Consumption: A systematic Review of Research on the Price Elasticity of Demand for Food

<sup>16</sup> OECD data, meat consumption <https://data.oecd.org/agroutput/meat-consumption.htm>

<sup>17</sup> The Protein Puzzle The consumption and production of meat, dairy and fish in the European Union [http://www.pbl.nl/sites/default/files/cms/publicaties/Protein\\_Puzzle\\_web\\_1.pdf](http://www.pbl.nl/sites/default/files/cms/publicaties/Protein_Puzzle_web_1.pdf)

<sup>18</sup> [http://www.eea.europa.eu/data-and-maps/daviz/per-capita-eu-27-consumption-1#tab-chart\\_1](http://www.eea.europa.eu/data-and-maps/daviz/per-capita-eu-27-consumption-1#tab-chart_1)



15,000 tons of “high-quality beef”; this will be over and above the other quota concessions.<sup>19</sup>

There is **consistent evidence** that high levels of animal product consumption, particularly of **processed meat and red meat**, are associated with **various chronic diseases** and an elevated risk of **premature death**.<sup>20</sup> Meat consumption contributes to the intake of saturated fat which is linked by long-standing evidence to premature death from cardiovascular disease, the foremost cause of death in Europe.<sup>21</sup> the International Agency on Research on Cancer (IARC) recently classified **processed meat** (e.g. sausages, ham, canned meat, salamis) as “carcinogenic to humans” and **red meat** as “probably carcinogenic to humans”.<sup>22</sup><sup>23</sup> High meat consumption is associated with **obesity**<sup>24</sup><sup>25</sup>, **type-2 diabetes**<sup>26</sup>, **Alzheimer’s Disease**<sup>27</sup> and **probably kidney failure**<sup>28</sup>.

**The nutritional and public health aspects of significantly increased consumption of meat have not been taken into account.**

#### **See Annex 2 – *Elimination of tariffs relevant for health***

#### **4. CETA does not address the global challenge of antimicrobial resistance (AMR)**

**High levels of meat and animal product consumption underpin an intensive livestock production model that is a major driver of antimicrobial resistance (AMR),** which poses a major threat to both human and animal health. If current trends continue, drug-resistant infections could kill 10 million people per year globally by 2050 at a cumulative cost of 100 trillion USD.<sup>29</sup> So-called ‘superbugs’ are strains of bacteria that have become multi-drug resistant; their prevalence is largely fuelled by inappropriate use of antibiotics. All this means that highly contagious and/or potentially deadly diseases (e.g., pneumonia, cancer) could soon become incurable, whereas life-saving interventions including surgeries could become too dangerous because antibiotics are ineffective.

<sup>19</sup> <http://www.livingstonintl.com/our-experts-speak/closer-look-ceta-part-3-tariff-reductions-benefit-chemical-telecom-industries/>

<sup>20</sup> <http://www.health.harvard.edu/staying-healthy/becoming-a-vegetarian>

<sup>21</sup> Association of Specific Dietary Fats With Total and Cause-Specific Mortality  
<http://archinte.jamanetwork.com/article.aspx?articleid=2530902>

<sup>22</sup> IARC Monographs evaluate consumption of red meat and processed meat [https://www.iarc.fr/en/media-centre/pr/2015/pdfs/pr240\\_E.pdf](https://www.iarc.fr/en/media-centre/pr/2015/pdfs/pr240_E.pdf)

<sup>23</sup> The Lancet Oncology, Carcinogenicity of consumption of red and processed meat  
[http://www.thelancet.com/pdfs/journals/lanonc/PIIS1470-2045\(15\)00444-1.pdf](http://www.thelancet.com/pdfs/journals/lanonc/PIIS1470-2045(15)00444-1.pdf)

<sup>24</sup> Meat consumption is associated with obesity and central obesity among US adults  
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2697260/>

<sup>25</sup> Meat consumption providing a surplus energy in modern diet contributes to obesity prevalence: an ecological analysis  
<http://bmcnutr.biomedcentral.com/articles/10.1186/s40795-016-0063-9>

<sup>26</sup> Food sources of fat may clarify the inconsistent role of dietary fat intake for incidence of type 2 diabetes  
<http://ajcn.nutrition.org/content/early/2015/04/01/ajcn.114.103010>

<sup>27</sup> Using Multi-country Ecological and Observational Studies to Determine Dietary Risk Factors for Alzheimer’s Disease  
<http://www.tandfonline.com/doi/full/10.1080/07315724.2016.1161566>

<sup>28</sup> Red Meat Intake and Risk of ESRD <http://jasn.asnjournals.org/content/early/2016/07/13/ASN.2016030248>

<sup>29</sup> The Review on Antimicrobial Resistance (2016) Tackling drug-resistant infections globally: final report and recommendations. <http://bit.ly/1ToZXcw>



Via tariff elimination, trade in meat and meat products is expected to increase under the Agreement. Increase in trade and resulting competition may result in further consolidation and enlargement of farm holdings, which is associated with increased levels of antibiotics use.<sup>30</sup> **While CETA opens up agricultural markets, it does not address the associated risks linked to AMR and does not contain specific measures needed to protect the consumer and patients from AMR.**

## 5. CETA has the potential to undermine the quality standard and the affordability of Services of General Interest (SGEI) (social services, healthcare, education, water)

In Annex I of CETA, the EU has made a general horizontal reservation with regard to public services, and a health sector specific reservation covering publicly and privately funded health services.<sup>31</sup> Some Member States made complementary reservations with regard to both health and social services.<sup>32</sup>

CETA is problematic because it **limits the freedom of governments** to make policy decisions on they wish to organise services of general interests relevant for health (social, healthcare, education, water) by giving incentives for further liberalisation and making it **financially more difficult to reverse such a decision** for the following reasons:

1. reservations in CETA only apply fully if those social, health, education and water services are publicly funded; That would have implications for specific healthcare service providers such as the Belgian mutualités which unanimously have raised concerns about this issue<sup>33</sup>
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;
3. concerning Annex I, CETA contains a controversial ‘ratchet clause’, limiting the scope of the reservations<sup>34</sup>

<sup>30</sup> Thomas Van Boeckel et al. (2015) Global trends in antimicrobial use in food animals. Proceedings of the National Academy of Sciences. <http://www.pnas.org/content/112/18/5649.abstract>

<sup>31</sup> Table with EU's reservations on public services – extracts from TiSA and the CETA services chapter [http://trade.ec.europa.eu/doclib/docs/2015/february/tradoc\\_153173.pdf](http://trade.ec.europa.eu/doclib/docs/2015/february/tradoc_153173.pdf)

<sup>32</sup> For **Health services**, national complementary reservations may be found in the schedules of **AT, BE, BG, CY, CZ, FI, FR, LT, MT, PL, SI, SK and UK**. For **Health and Social services**, national complementary reservations may be found in the schedules of **LT**. For **Social Services** national complementary reservations may be found in the schedules of **BE, CY, CZ, DE, DK, EL, ES, FI, FR, HU, IE, IT, LT, MT, PL, PT, RO, SK, SL, and UK**.

<sup>33</sup> Les mutualités belges sont unanimes : Il ne faut pas signer l'accord de libre-échange entre l'UE et le Canada.

[https://www.mc.be/actualite/communiqué-presse/2016/accord\\_ceta.jsp](https://www.mc.be/actualite/communiqué-presse/2016/accord_ceta.jsp)

<sup>34</sup> article 8.15 (c) Reservations and exceptions 1. Articles 8.4 through 8.8 do not apply to: (p 51) <http://ow.ly/Qcz0304DUfg>



CETA does not respect the recent recommendation made by the European Parliament in February 2016 with regard to the Trade in Services Agreement (TiSA) which is relevant for all Trade Agreements dealing with services, including CETA.

*“Regarding market access, to exclude, in line with Articles 14 and 106 TFEU and Protocol 26, current and future services of general interest and services of general economic interest from the scope of application of the agreement (including, but not limited to, water, health, social services, social security systems and education, waste management and public transport); to ensure that EU, national and local authorities retain the full right to introduce, adopt, maintain or repeal any measures with regard to the commissioning, organisation, funding and provision of public services; to apply this exclusion irrespective of how the public services are provided and funded” (European Parliament recommendation to the Commission).”<sup>35</sup>*

There is a need for an **independent social impact assessment** about the possible impact of CETA on SGEI, including social, health education and water services as there is lack of evidence on the possible impact of CETA on availability, affordability, accessibility, quality and equal treatment in access concerning SGEI. In the meantime, the most preferable option would be to have **a full carve-out of services of general interest (SGEI) from CETA** in a renegotiated treaty. By giving a refreshed mandate to the Commission, Member States can exclude SGEI from it in the same way that audio-visual services have been excluded in the negotiating mandate for TTIP.<sup>36</sup>

### See Annex 3 – Why CETA is problematic for Services of General Interest

## 6. CETA does not address health sustainability and alcohol related harm

**The Sustainable Development Chapters of CETA fail to recognise the public health sustainability aspects by omitting any reference to public health relevant treaties, commitments or objectives.** This is a failure in light of the recently adopted Sustainable Development Goals(SDGs)<sup>37</sup> which are legally binding for both Canada and the EU. CETA should have been an opportunity to contribute to the implementation of the SDGs.

**CETA remains inconsistent with public health when it remains neutral on alcohol** and does not acknowledge the link between alcohol consumption and the development of NCDs and other forms of alcohol related harm (increased violence, crime, road deaths). **This has the potential to harm both European and Canadian consumers' health.**

<sup>35</sup> European Parliament resolution of 3 February 2016 containing the European Parliament's recommendations to the Commission on the negotiations for the Trade in Services Agreement (TiSA) (2015/2233(INI)) <http://www.europarl.europa.eu/sides/getDoc.do?pubRef=/EP/TEXT-TA+P8-TA-2016-0041+0+DOC+XML+V0//EN>

<sup>36</sup> Directives for the negotiation on the Transatlantic Trade and Investment Partnership between the European Union and the United States of America 11103/13 DCL 1, 17 June 2013 <http://data.consilium.europa.eu/doc/document/ST-11103-2013-DCL-1/en/pdf>

<sup>37</sup> [http://trade.ec.europa.eu/doclib/docs/2013/july/tradoc\\_151626.pdf](http://trade.ec.europa.eu/doclib/docs/2013/july/tradoc_151626.pdf)



## 7. CETA is not based on an assessment of its potential impacts on the price of medicines

While CETA does make a reference to the **Doha Declaration on the TRIPS Agreement and Public Health** adopted on 14 November 2001<sup>38</sup> which recognises concerns about the effect of Intellectual Property Rights (IPR) on medicine prices, it **does not recognise that** IPRs are acting as an insurmountable barrier to equitable access to medicine. This is particularly problematic for Canada given that a per capita basis, Canadian drug costs are already the second highest in the world after the US, and CETA's provisions could increase Canadian drug costs by between 6.2% and 12.9% starting in 2023.<sup>39</sup>

Although CETA will only affect intellectual property rights in Canada—not the EU, by securing in the agreement eight years of market exclusivity, the Agreement would undermine a critical democratic debate and lock Europeans and Canadians into a model of innovation that fails to address priority health needs, while simultaneously allowing pharmaceutical companies to charge consumers exorbitant prices that bear no relation to their research and development costs. As yet, neither the EU nor the Canadian government have undertaken an assessment of the potential impact on medicine prices as a result of CETA and closer regulatory cooperation.

## 8. The joint interpretative declaration does not fix the health problems of CETA

Although the recently leaked ***Joint Interpretative Declaration on the Comprehensive Economic and Trade Agreement (CETA) between Canada and the European Union and its Member States*** makes positive statements mentioning public health among the public interest policies and recognises “*that the principal purpose of trade is to increase the well-being of citizens, by supporting jobs and creating sustainable economic growth;*”<sup>40</sup> by its nature, it cannot re-open the already negotiated text and therefore cannot appropriately address the identified public health shortcomings.

The declaration is intended to reassure stakeholders including the health community that the ‘right to regulate in the public interest’ of governments and of the EU would remain unaltered. It is to be welcomed that public health is the first in the list of ‘legitimate public policy objectives’ to be cited, together with consumer protection, food and product safety, environment and labour protection, which all also have an impact on public health. However, the declaration is not sufficient nor reassuring, as it indicates that trade negotiators recognize that these aspects are not sufficiently clear in the legal text.

Of particular interest is the phrase with regard to investment protection that “*CETA include provisions that allow Parties to issue binding notes of interpretation. Canada and the EU and its MS are committed to using these provisions to avoid and correct and misinterpretation of CETA by Tribunals.*”

<sup>38</sup> [https://www.wto.org/english/thewto\\_e/minist\\_e/min01\\_e/mindecl\\_trips\\_e.htm](https://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.htm)

<sup>39</sup> HAI, Commons Network, Public Citizen: CETA and pharmaceuticals: impact of the trade agreement between Europe and Canada on the costs of prescription drugs <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4108121/>

<sup>40</sup> <http://download.krone.at/pdf/ceta.pdf>



This confirms that our concerns that the agreement may well be misinterpreted or abused are well-founded. The idea that these issues can be corrected at a later date and the commitment “to addressing in a timely manner any shortcomings that may emerge” does not seem pragmatic nor credible.

The commitment to voluntary regulatory cooperation gives no reassurance that there would be no race to the bottom, or regulatory chill when it comes to health-relevant standards.

Concerning Services of General interest, the draft EU-Canada declaration will not address the legally binding nature of either the negative list approach or the ‘ratchet clause’ as **the legally binding declaration** means that it would be an **interpretative instrument**, which can be used in the event of litigation. Governments may still be asked under CETA to pay compensation (given ICS proceedings) and/or possibly asked to make other commitments if they renege on certain liberalisation commitments.

This Declaration can have the legal value that preambles have previously been given in international treaties. Given that it is badged as an 'interpretative' statement, arbitrators in the ICS would view it as an instrument to inform their interpretations. This is worrying as:

- Tariff eliminations and market access commitments which could harm our health will take place without taking into account their health impacts;
- There is still no commitment in CETA to address Antimicrobial Resistance as a global public health challenge;
- It will not result the general exclusion of Services of General Interest, regardless of their funding;
- The statement reaffirming the right to regulate to achieve public health policy objectives with regard to investment protection is nothing but a statement of the *status quo* and does not in any way limit the applicability of existing standards of investor protection; The declaration fails to highlight policy coherence between trade and health by not addressing public health sustainability, alcohol related harm and will not fix the broken medication innovation model.

## Rejection of CETA is an opportunity for a better deal with a more progressive trading partner

The European Public Health Alliance is not opposed to free trade, nor the concept of international trade deals with different trading blocs or countries. We firmly believe that international trade deals can be beneficial to public health on the condition that negotiations establish appropriate regard to the public interest and set the right conditions to ensure protection and continuous improvement of public health and rights, and access to quality health services and affordable medicines.



CETA could increase the availability of products causing poor health (mainly tobacco and unhealthy food), contribute to European obesity rates, the diet-related Non Communicable Disease (NCD) epidemic and the growing threat of Antimicrobial Resistance. It fails to guarantee the protection of public services including healthcare; has the possibility to undermine public health policy-making by limiting the public policy space via investment protection arbitration rules (including tobacco control measures); and does not ensure policy coherence between trade and public health policy.

At the national level, where trade policy objectives are first set, health considerations are often absent or ignored by decision-makers. National trade policy objectives are mostly defined by the interplay of the economic interests at stake. If the costs in terms of higher prices for medicines, or reduced capacity to regulate to protect and promote health are not made visible, they will not even be part of the “grand bargain” of trade negotiations. Making these costs visible is a necessary, if not essential, step toward tackling the political determinants of health.<sup>41</sup>

EU Trade Ministers agreed<sup>42</sup> to press on with CETA, despite widespread protests and continuing concerns, including from a broad group of civil society and consumer organisations as well as trade unions<sup>43</sup>. Once CETA is approved by Trade Ministers and signed by both the EU and Canada, Parliaments across the EU will have their opportunity to show that they have heard these concerns.

There is every reason to believe that reopening negotiations on the above-mentioned aspects of the text would enable a much better deal for Europe to be achieved and which would be more able to win support, as well as setting a genuinely progressive blueprint for future trade deals with other parts of the world. The European Public Health Alliance now calls on the European Parliament and national parliaments to protect public health by refusing to ratify the agreement and call for a better deal for health and consumers.

<sup>41</sup> Trade Policy and Health: Adding Retrospective Studies to the Research Agenda; Comment on “The Trans-Pacific Partnership: Is It Everything We Feared for Health?” [http://www.ijhpm.com/article\\_3272.html](http://www.ijhpm.com/article_3272.html)

<sup>42</sup> Assumed outcome of the Trade Council of 18th October – potential date of the publication of the EPHA position (before?)

<sup>43</sup> Civil society groups call on European governments to reject the CETA agreement <https://www.etuc.org/press/civil-society-groups-call-european-governments-reject-ceta-agreement#.V-kqRKOzhTU>

## About EPHA

EPHA is a change agent – Europe's leading NGO advocating for better health. We are a dynamic member-led organisation, made up of public health NGOs, patient groups, health professionals, and disease groups working together to improve health and strengthen the voice of public health in Europe. EPHA is a member of, among others, the Social Platform, the Health and Environment Alliance (HEAL), the Transatlantic Consumer Dialogue (TACD), the Sustainable Development Goals (SDG) Watch Europe and the Better Regulation Watchdog.

EPHA's Transparency register number is 18941013532-08.

**Trade for Health, not health for trade!** The objective of EPHA's campaign on EU international trade policy is to protect and promote public health, to ensure policy coherence between trade and public health and to guarantee policy and regulatory space for governments and the EU.

### Further reading

EPHA Position Paper – June 2016 - Tobacco and Public Health in TTIP. [>>read more](#)

EPHA Position Paper - November 2015 - Investment Protection in TTIP and Trade Agreements. [>>read more](#)

EPHA Position Paper - August 2015 – How to Include Public Health into the EU Trade Strategy [>>read more](#)



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