



## EUROPEAN COMMISSION

Directorate-General for Trade

Directorate E - Neighbouring countries, USA and Canada  
The Director

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DG TRADE E./IGB

Rt Hon John Healey MP  
Chair, All-Party Parliamentary Group on TTIP  
House of Commons  
London SW1A 0AA

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Dear Mr Healey,

When we last met in March, you asked me to explain how the Transatlantic Trade & Investment Partnership (TTIP) negotiations could affect the National Health Service (NHS), particularly with regards to the mix of public and private health service delivery that the NHS currently employs. Now that the consultation on investment protection in TTIP is well underway, I would like to set out the Commission's view on the subject in writing. I am sorry that this letter has taken some time, but I wanted to be as clear as possible on all the elements involved.

There are three aspects to this question from a trade policy perspective: services, public procurement, and investment protection. The first two aspects are governed not only by bilateral trade policy, but also at a global level in the World Trade Organisation (WTO) agreements on services (GATS) and public procurement (GPA) respectively. This means that it is important to consider not only the potential content of TTIP, but also what the UK (as an EU Member State) has already committed to in the WTO. Furthermore, there are ongoing plurilateral negotiations on services called the Trade in Services Agreement (TiSA), as well as other EU bilateral trade negotiations, in which the UK would also take commitments.

First, on services: although health services are in principle within the scope of these agreements and ongoing negotiations, we are confident that the rights of EU Member States to manage their health systems according to their various needs can be fully safeguarded. The GATS has been in force since 1995 without any adverse effects on Member States' ability to do so. The GATS and all EU free trade agreements contain a specific safeguard (GATS Article I:3b<sup>1</sup>) which exempts all services supplied in the exercise of governmental authority.

Furthermore, the EU's bilateral agreements either exclude or make specific reservations for publicly funded health services (depending on whether positive or negative listing is used). For example, in the recent EU-Korea agreement<sup>2</sup>, the EU and its Member States

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<sup>1</sup> See [http://www.wto.org/english/docs\\_e/legal\\_e/26-gats.pdf](http://www.wto.org/english/docs_e/legal_e/26-gats.pdf)

<sup>2</sup> See <http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=OJ:L:2011:127:FULL&from=en>

have reserved full policy space for publicly funded health services, such as hospital and residential health services or ambulance services, by not including them in the scope of commitments. This policy space means that Member States do not need to provide access to their markets for foreign companies, and even if they do give access, they can discriminate between foreign companies and EU/domestic ones.

Member States can also limit the access of foreign doctors to work within their health services system. For example, the UK has done this by reserving the right in trade agreements (such as EU-Korea) to make the establishment of foreign doctors under the NHS subject to medical manpower planning.

These protections remain valid irrespective of whether commitments are scheduled in positive or negative listing. Our current experience in negotiating the EU's trade agreement with Canada shows that policy space for future restrictions can be fully preserved in an agreement which uses negative listing. I would like to underline that the so-called "ratchet" clause – a common feature in negative listing which locks in future liberalisation once and forever – explicitly does not apply to measures for which policy space is reserved in the agreement.

As a result of the EU's approach, Member States such as the UK are free to maintain and adopt new measures to control access to their health services market by foreign suppliers, without constraints under EU trade agreements. The EU does not intend to change its approach to health services in trade negotiations for TTIP.

Secondly, on public procurement, it is important to underline the difference between the way Member States organise the sector and the extent of public and private involvement, and the disciplines that apply once a public authority decides to turn to the market for execution of works or the provision of services through the award of a concession. The current NHS commissioning model (sometimes referred to as the purchaser-provider split) is decided by the UK government, not by the EU's rules on public procurement.

These rules applying to social and other specific services, including healthcare, are covered by the Directive 2004/18/EC<sup>3</sup> on public procurement (which from 2 April 2016 will be repealed by Directive 2014/24/EU<sup>4</sup>). When contracting authorities such as NHS commissioners undertake a procurement exercise above the given value threshold, they are required to follow the basic requirements laid out in the Directive. These include, for example, that the technical specification must be laid down at the start of the procurement process and that the results of the award procedure must be published. The public authority must also comply with the basic principles of the Treaty such as the transparency requirement and the obligation to treat economic operators equally, without discrimination if and insofar as the services in question are of cross-border interest. But none of these rules prevent Member States from liberalising the health sector nor from de-liberalising it. The EU does not intend to change its approach to public procurement for health services in TTIP.

Thirdly, investment protection and Investor-State Dispute Settlement (ISDS) are said to pose a risk to the possibility of changes in future to the NHS commissioning model and the current mix of public and private health service delivery. However, changes to NHS policy over the past two decades have neither been required nor indirectly affected by EU

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<sup>3</sup> See <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2004:134:0114:0240:en:PDF>

<sup>4</sup> See <http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32014L0024&from=EN>

trade policy, whether bilateral or multilateral. Nor have they been affected by the UK's 94 existing bilateral investment treaties, the vast majority of which contain provisions on ISDS.

If a future UK government, or a public body to which power has been devolved, were to reverse decisions taken under a previous government, for example by discontinuing services provided by a foreign operator, it would be entirely at liberty to do so. However, it would have to respect applicable UK law (as is the case now), for example the conditions for early termination of a contract.

In order for an investor to bring a successful ISDS case, it would need to prove that its rights under the relevant treaty had been breached, for example by expropriation without compensation, a denial of justice or manifestly arbitrary treatment. In such cases, an ISDS tribunal can award compensation but it cannot overturn national regulation, nor can it order repeal or reversal of a government's decision related to the organisation and the management of health services. Regardless of the content of TTIP, such cases are unlikely to happen in the UK. Member States are already required to respect applicable domestic and EU law regarding, for example, the conditions for early termination of contracts.

Of course, many questions have been asked about the investment protection and ISDS provisions in TTIP. With this in mind, the Commission has run a public consultation on investment protection and ISDS in TTIP. The aim of the consultation is to ensure that TTIP and future EU investment agreements reflect best practice, making the relevant provisions in TTIP more transparent and accountable than existing EU Member State treaties with the US, guaranteeing the rights of governments to legislate in the public interest, and preventing unjustified claims.

While the results of the consultation are still under analysis, we can already state with confidence that any ISDS provisions in TTIP could have no impact on the UK's sovereign right to make changes to the NHS.

I hope that this information clearly demonstrates that there is no reason to fear either for the NHS as it stands today, or for changes to the NHS in future, as a result of TTIP.

Thank you again for your continued interest in the TTIP negotiations. I look forward to further discussions with you as our work moves forward.

Yours sincerely,



Ignacio GARCIA BERCERO

CC: Bernd Lange (Chair, INTA Committee, European Parliament)

Trade Policy Committee Full Members