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Public Procurement and State Aid in National Healthcare Systems[*]

Vassilis Hatzopoulos[**]

1. Introduction

The recognition, by the ECJ, that healthcare services are services within the meaning of the Treaty, has very important legal implications, most of which are still to materialise. Free movement of patients, recognised in *Kohll, Smits & Peerbooms* and their progeny,[1] is just the tip of the iceberg. Much more crucial than accommodating the few thousands of 'peripatetic' patients moving from one state to another is the issue of financing high performance healthcare systems having universal coverage.

Financing healthcare and securing universal coverage, have traditionally been tasks attributed to the state. Indeed, even in 'an era of contractualised governance in the delivery of public services',[2] where the 'providential state' gives way to the 'regulatory state'[3] and where public spending containment is an absolute value, nobody in Europe seriously questions the need of public funding for healthcare.[4] However, once it is established that healthcare services are 'services' within the meaning of the Treaty and that there is a 'market' for healthcare, public money cannot reach this market in an arbitrary way. It has rightly been pointed out that 'while in the '90s the

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[1] Case C-158/96, *Kohll*, [1998] ECR I-1931; Case C-157/99, *Smits & Peerbooms*, [2001] ECR I-5473. For these cases and their progeny see V. Hatzopoulos, 'Killing national health and insurance systems but healing patients? The European market for health care services after the judgments of the ECJ in *Vanbraekel* and *Peerbooms*', CML Rev. (2002), 683-729, and more recently 'Health law and policy, the impact of the EU', n. 80 above. See also G. Davies, 'Welfare as a service', (2002) *LIEI* 27-40; P. Cabral, 'The Internal Market and the right to cross-border medical care', (2004) *ELRev*, 673-685, and A.P. van der Mei, 'Cross-border access to health care within the EU: Some reflections on *Geraets-Smits and Peerbooms* and *Vanbraekel'*, (2002) *ML*, 289-215 and 'Cross-border access to medical care: Non-hospital care and waiting lists', (2004) *LIEI*, 57-67. More recently see A. Dawes, 'Bonjour Herr Doctor: national healthcare systems, the Internal Market and cross-border medical care within the EU', (2006) *LIEI*, 167-182. For a full account of the relationships between EU and Health Law see T. Hervey and J. McHale, *Health Law and the European Union*, CUP (Cambridge, 2004).

[2] C. Bovis, 'Financing Services of General Interest in the EU: How do Public Procurement and State Aids Interact to Demarcate between Market Forces and Protection?' (2005) ELJ 79-109, 90.

[3] See G. Majone, 'The Rise of the Regulatory State in Europe' (1994) 17 West European Politics 77-101; F. McGowan & H. Wallace, 'Towards a European Regulatory State' (1996) 3 JEP, 560-576.

[4] Even in the most pro-competitive economies, where provision is increasingly secured through private means, such as the UK or the Netherlands, private finance initiatives are perceived as a complement – not an alternative – to public funding; see below 3.2.1.

debate concerned anti-competitive practices and Article 82 EC […] since the beginning of the current millenium, the main question has shifted to the means of financing public services and to state aids'.[5] Hence, public funds have either to be given out following a competitive tender based on objective and transparent criteria, or to be individually evaluated under the Treaty rules on state aids.

The aim of the present contribution is to examine (and to some extent to speculate upon) the ways in which the rules on public procurement and on state aids may affect the organization of public healthcare systems of member states. In order to better illustrate the resulting questions, we shall try to 'sit' the various findings on the national systems of six member states.

For the sake of clarity, the structure followed is simplistic and resembles that of a judgment: first, the legal framework needs to be reviewed in order to account for several recent developments which upset the legal scenery, (para. 2), then the law will be applied to the facts, in order to get a more precise idea of the ways in which the various healthcare systems are (or may be) affected by EC rules on state aid and public procurement (para. 3). Some conclusions will follow (para. 4).

2. Public procurement and state aid

Despite the fact that the relevant rules appear in different sections of the EC Treaty, public procurement and state aids are linked in many ways.[6]

2.1. Logical links between state aid and public procurement

First, there is a logical link. When the public authorities wish to favour specific players in a given market, they can do so in two ways: directly, by giving them public subsidies, or indirectly by awarding to them public contracts. Hence, both sets of rules are designed to prevent the public authorities from unduly meddling with markets. The rules on state aids (Articles 87 et seq EC) prohibit such money infusions, unless they are specifically 'declared compatible' by the Commission, following a notification procedure. The rules on public procurement, on the other hand, set in Directives 2004/17/EC and 2004/18/EC (the Public Procurement Directives),[7] require that public contracts are awarded following stringent requirements of publicity, transparency, mutual recognition and non discrimination. Respect for these requirements is overseen by national jurisdictions which have been awarded extraordinary powers to that effect by the so called 'procedures' Directive.[8]

Second, a logical conclusion stems from the above. Since both sets of rules pursue the same objectives, they must not apply simultaneously, but alternatively. Indeed, one of the conditions for the application of the rules on state aids is that the recipient of the aid be an undertaking – money transfers between public bodies or in favour of

[5] L. Idot, 'Les Services d'intérêt général économique et les règles de concurrence' in J.V. Louis & St. Rodriguez, *Les services d'intérêt économique général et l'UE*, (2006) Bruylant, 39-63, 41, unofficial translation.

[6] For a more complete account of the relationship between the two series of rules see A. Bartosch, 'The relationship of Public Procurement and State Aid Surveillance – The Toughest Standard Applies?' (2002) CMLRev 35 and, more recently, C. Bovis, 'Financing Services of General Interest … above.

[7] Directive 2004/17/EC, for Procurement in the Utilities Sector, OJ [2004] L 134/1; Directive 2004/18/EC, the 'General' Procurement Directive, OJ [2004] L 134/114.

[8] Directive 89/665/EEC of the Council of 21 December 1989 on the coordination of the laws, regulations and administrative provisions relating to the application of review procedures to the award of public supply and public works contracts, OJ [1989] L 395/33.

non-commercial entities are not caught. On the other hand, public procurement rules are deemed to apply to the so called 'public markets' (marches publics), 'where the state and its organs enter in pursuit of public interest' and not for profit maximisation.[9] Hence, 'contracting entities' in the sense of the public procurement directives are the state, regional and local authorities and 'bodies governed by public law'. The latter's legal form (public scheme, company, etc) is irrelevant,[10] as long as three conditions are met: they need a) to have legal personality, b) to be financed or controlled by the state (or an emanation thereof) and c) to have been 'established for the specific purpose of meeting needs in the general interest, not having an industrial or commercial character'. The Court has made it clear that these are cumulative conditions.[11] Member states have been invited to enumerate in Annex I of Directive 93/37/EC,[12] now replaced Annex III of Directive 2004/18/EC, national 'bodies' which fall in the above category.

However, this enumeration is not exhaustive and the Court has been called upon in several occasions to interpret the above three conditions. Unsurprisingly, the most controversial condition has been the one related to the opposition between activities in the pursuance of general interest and activities of an industrial or commercial character. Following the judgments of the Court in the *Mannesmann*, the *BFI Holding* and, more recently, the *Agora & Excelsior* cases[13] two series of conclusions may be drawn.

First, that the fact that some activity serves the general interest does not, in itself, exclude the industrial or commercial character of that very activity. Or, to use the Court's wording, there is 'a distinction between needs in the general interest not having an industrial or commercial character and needs in the general interest having an industrial or commercial character'.[14]

Second, in order to ascertain in which of the above categories an activity falls, the Court uses a set of criteria (faisceau d'indices) which may be summarised as follows: a) the absence of considerable competition in providing the same activity, b) the existence of decisive state control over the said activity,[15] c) the pursuance of the activity and the satisfaction of the relevant needs in a way different from what is offered in the market place and d) the absence of financial risk, are all factors which point towards the absence of industrial and commercial character.[16]

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[9] See C. Bovis, above at 82; see also by the same author 'Recent Case law Relating to Public Procurement: A Beacon for the Integration of Public Markets' (2002) CMLRev 1025-1056; and 'The Regulation of Public Procurement as a Key Element of European Economic Law' (1998) ELJ 220-242.

[10] Case C-360/96 *BFI Holding* [1998] ECR I-6821, Rec. 53.

[11] See e.g. Case C-44/96 *Mannesmann Anlangebau Austria* [1998] ECR I-73 and Case C-360/96 *Gemeente Arnhem* [1998] ECR I-6821.

[12] Directive 93/37/EEC of the Council, of 14 June 1993, concerning the coordination of procedures for the award of public works contracts, OJ [1993] L 199/54.

[13] For the two first cases see the notes above; see also Case C-223&260/99 *Agora & Excelsior* [2001] ECR I-3605.

[14] *Agora* Rec. 32.

[15] Not the entity providing it, this is a distinct condition directly enumerated in the Directives, see above.

[16] See. C. Bovis, *EC Public Procurement: Case law and Regulation* (2006) OUP, Oxford, Chapter 7; S. Arrowsmith, *The Law of Public and Utilities Procurement* (2005) Sweet & Maxwell, London, Chapter 5. H. Synodinos, *Application of the competition rules during the conclusion and execution of public procurement contracts* (in Greek) (2001), at 72 *et seq.*

These criteria are very similar to the ones used by the Court in order to ascertain whether an entity is to be viewed as an 'undertaking'.[17] Therefore, it would seem that, to the extent that the two series of criteria are applied consistently, an entity which is not an undertaking will, more often than not, be considered to be a contracting entity. Hence, any given entity will be subject either to the competition and state aid rules or to the ones on public procurement– but not both.[18] This viewpoint also finds support in the very text of the Utilities Procurement Directive, both in its previous version (Directive 93/38/EC Article 8.1)[19] and in its current version (Directive 2004/17/EC, Article 30) where it is stated that 'contracts […] shall not be subject to this Directive if, in the Member State in which it is performed, the activity is directly exposed to competition on markets to which access is not restricted'.

2.2. Formal links between state aid and public procurement

This logical link has been turned into a formal one in the Court's judgment in *Altmark*[20] and the Commission's '*Altmark* package'.[21] In this case the Court reversed previous case law in which it followed a 'state aid' approach, in favour of a 'compensation' approach.[22] Before *Altmark*, any subsidy given to an undertaking for the accomplishment of some service of general interest, would qualify as a state aid. Such aid could be upheld, by virtue of Article 86(2) EC, provided it were duly notified under Article 88 EC.[23] In *Altmark* the Court held that such financial support may not constitute a state aid at all, provided four conditions are met, cumulatively:

'First, the recipient undertaking must actually have public service obligations to discharge, and the obligations must be clearly defined. Second, the parameters on the basis of which the compensation is calculated must be established in advance in an objective and transparent manner. Third, the compensation cannot exceed what is necessary to cover all or part of the costs incurred in the discharge of the public service obligations, taking into account the relevant receipts and a reasonable profit. Finally, where the undertaking which is to discharge public service obligations, in a specific case, is not chosen pursuant to a public procurement procedure which would allow for the selection of the tenderer capable of providing those services at the least cost to the community, the level of compensation needed must be determined on the

[17] For these criteria see below 3.3.2; more in detail for the health sector, see V. Hatzopoulos, 'Health Law and Policy: the Impact of the EU, in De Burca (ed) *EU Law and the Welfare State: In Search of Solidarity*, EUI/OUP (2005) p. 123-160, 149-155. C. Bovis cited above n. 1 takes up the same point at p. 84, footnote 20.

[18] See also S. Arrowsmith above n. 16, at p. 265, taking up this point.

[19] Directive 93/38/EC of the Council, of 14 June 1993, coordinating the procurement procedures of entities operating in the water, energy, transport and telecommunications sectors, OJ [1993] L 82/39; Art. 8(1) of this Directive was interpreted by the Court in Case C-392/93 *The Queen and HM Treasury, ex parte British Telecommunications PLC* [1996] ECR I-1631.

[20] Case C-280/00 *Altmark* [2003] ECR I-7747; for this case see among many M. Merola & C. Medina, 'De l'arrêt Ferring à l'arrêt Altmark: continuité ou revirement dans l'approche du financement des services publics' (2003) CDE, p.639-694

[21] For which see below, in the following paragraphs.

[22] See among many, C. Bovis, above n. 1; J. Y. Chérot, 'Financement des obligations de service public et aides d'état' (5/2005) *Europe*, chron 5.

[23] See for instance Case C-387/92 *Banco Exterior de Espana* [1994] ECR I-877; Case T-106/95 *FFSA v. Commission* [1997] ECR II-229 and on appeal Case C-174/97 P [1998] ECR I-1303;

basis of an analysis of the costs which a typical undertaking, well run and adequately provided with means of transport, would have incurred.'[24]

From the very wording of the fourth condition it follows that the default setting for the attribution and finance of some public service obligation is through public procurement. Only in the exceptional circumstances in which this is not the case, then the prices should be determined according hypothetical market conditions.

More than the wording, the substantive content of this fourth condition suggests that the application of the procurement rules will be the means to avoid the applicability of the state aid rules. For one thing, it will be very difficult to prove what the costs of 'a typical undertaking, well run and adequately provided with means of transport' would have been in a hypothetical market (when 'well run' is well enough and what are 'adequate' means of transport?). Most importantly, for most services of general interest there is no market other than the one emerging under the impulse of EC law. Hence, it will be virtually impossible to simulate such conditions in order to ascertain what the cost structure of a 'well run typical undertaking' would be.[25] The only way to benefit from the Court's judgment in *Altmark* and evade the application of the rules on state aids, would be to attribute public service contracts and the related funding following public procurement procedures.[26]

What is more, the three first conditions of the *Altmark* test, are also certain of being fulfilled by the award of public service contracts through public tenders – although they do not necessarily require such tenders. The award contract will fulfil the formal requirement of condition number one. The content of the tender documents will satisfy conditions number two and three. [27]

The judgment of the Court in *Altmark* has been followed by the so called 'Altmark package' also known as the 'Monti-Kroes package'. This consists of three documents, one directive, one decision and one communication.

- Directive 2005/81/EC[28] modifies Directive 80/723/EEC [29] and requires any undertaking which 'receives public service compensation in any form whatsoever in relation to such service and that carries on other activities' to

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[24] The excerpt reproduced here resumes recitals 89-93 of the Court's judgment and is taken from the Commission's '*Altmark* decision', rec. 4, for which see below in the following paragraphs.

[25] See further, for the difficulties of these conditions L. Idot, above n. 5.

[26] Since the fourth condition is the most hard to fulfil, national authorities often start the examination of any given measure from this condition and immediately dismiss the applicability of the *Altmark* criteria; see e.g. Bulgarian Commission for the Protection of Competition, 2 November 2006, Dec. n. 346, Case K3K-175/2006, *Elena Avtotransport*, reported and briefly commented by D. Fessenko in e-Competitions e-Bullentin, February 2007-II, n. 13146.

[27] It may be that the Court in *Altmark* got inspired from the draft proposal for a regulation of the EP and the Council on action by member states concerning public service requirements and the award of public service contracts in passenger transport by rail, road and inland waterway, COM (2002) 107 final, of 21.2.02 which provided for the award of public service contracts following competitive and transparent tenders; this proposal, however, has been the object of intense negotiations between the EP and the Council and is currently on the verge of being adopted on the basis of a substantially modified draft, see COM (2006) 805 final, of 12.12.2006.

[28] OJ [2005] L 312/47.

[29] Directive 80/723/EEC of the Commission, of 25 June 1980, on the transparency of financial relations between Member States and public undertakings, OJ [1980] L 195/35.

proceed to the accounting separation of activities for which it receives compensation from the others.

- More importantly, Commission Decision 2005/842/CE,[30] adopted on the basis of Article 86(3), provides for some kind of 'block exemption' from the state aids rules where the *Altmark* conditions are not met. This 'block exemption' covers three categories of service providers: a) any service provider of small size (turnover of under EUR 100 million during the last two years) receiving a limited amount of compensation EUR 30 million annually), b) transport serving up to a certain number of passengers and c) hospitals and social housing undertakings, without any limitation. This text offers important information concerning the way in which the Commission will apply the four *Altmark* criteria – especially the one concerning 'just' compensation. Subsidies falling within the scope of the Decision qualify as state aids (according to *Altmark)* but are deemed compatible with the internal market and need not be notified to the Commission.

- Finally, the 'Community Framework for State aid in the form of public service compensation'[31] sets the Commission's position in respect of those subsidies which do not fall neither under the *Altmark* judgment (and hence, do not constitute aid) nor under the '*Altmark* Decision' (and constitute aid which is automatically authorised by the Commission) and need to be notified in order to obtain an individual declaration of compatibility.

In the light of the above texts, there is no doubt that, despite other approaches previously followed by the Court,[32] currently the so called 'compensation' approach prevails, in order to determine whether public funds given out for the accomplishment of services of general interest constitute an aid. Within this approach the rules on public procurement play a double role. *Externally*, as a means of defining the scope of application of the state aid rules: an entity charged with some mission of general interest that qualifies as a contracting entity, is unlikely to be an undertaking. Therefore, it may receive public funds without being constrained by the rules on state aids. *Internally*, as the main means for the application of Article 86(2) EC in the field of state aid, according to the *Altmark* test.

Then, in practice, any entity receiving public money should answer the following questions in order to position itself in respect of the state aid rules:

a) is it an undertaking or not? If it is itself a contracting entity then the most likely answer is negative; if, however, the answer is positive then,

b) is the money received compensation for some public service in the meaning of the *Altmark* judgment? If the undertaking in question has not been chosen following a public tender procedure, the likely answer is negative and the moneys received will constitute an aid; then

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[30] Decision 2005/842/EC, of the Commission, of 28 November 2005, on the application of Article 86(2) of the EC Treaty to State aid in the form of public service compensation granted to certain undertakings entrusted with the operation of services of general economic interest, OJ [2005] L 312/67.

[31] 2005/C OJ [2005] C 297/4. In a different context it would make sense to enquire what a 'Community Framework' is and how this is different from a Communication, if at all.

[32] For which see, among others, C. Bovis, 'Financing Services of General Interest…' above n.1, who distinguishes a) the state aid approach, b) the compensation approach and c) the *quid pro quo* approach.

c) does the undertaking fall in any of the categories contemplated by the *Altmark* Decision, in which case the aid is deemed lawful, without notification being necessary? If the answer is negative, then

d) how can the terms and conditions attached to the aid be formulated in order for it to be individually declared lawful by the Commission, according to its 'Framework' Communication.

2.3. Procurement principles as a means of regulating the internal market

The importance of the public procurement rules and principles, as a means of regulating the flow of public funds in the member states, has been greatly stressed by both the Court and the Commission in these last years.[33] In fact, the relevant case law together with the *Altmark* judgments, discussed above, constitute the two main developments of economic law in the Court's case law, these last years.

The Court has handed down two series of judgments in this respect.

First, the Court has held that, next to the specific and technical rules of the Public Procurement Directives, a series of general principles apply in all circumstances where public money is put into the market; that is, on top of, or outside the scope of, the Procurement Directives. The Court began by holding, in case *Commission v. France, Nord Pas de Calais,*[34] that on top of the Directive's technical rules, a general principle of non-discrimination should also be respected in any award procedure. More importantly, in a series of judgments starting with *Telaustria*,[35] a case concerning a concession in the field of telecommunications, the Court held that the same principle also applies to concession contracts (and presumably any other type of contract which involves public funding and is not covered by the Procurement Directives). *Coname*[36] concerned the direct award, in Italy, of a contract for the service covering the maintenance, operation and monitoring of the methane gas network. In its judgment the Court further explained that the above requirement of non-discrimination carries with it a further requirement of transparency, satisfied by adequate publicity. This trend was further pursued some months later in *Parking Brixen,*[37] another Italian case concerning the construction and management of a public swimming-pool. The Court found that 'a complete lack of any call for competition in the case of the award of a public service concession does not comply with the requirements of Articles 43 EC and 49 EC *any more than with the principles of equal treatment, non-discrimination and transparency'*.[38] The same was confirmed some days later in *Contse,*[39] concerning the award of a contract for the supply of home oxygen equipment in Spain.

Picking up on the momentum created by these judgments, the Commission has come up with an interpretative Communication 'on the community law applicable to contract awards not or not fully subject to the provisions of the public procurement directives' (the so called *de minimis* Communication).[40] This Communication covers

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[33] See C. Bovis, 'Developing Public Procurement Regulation : Jurisprudence an its Influence on Law Making' (2006) CMLRev 461-495.

[34] Case C-225/98, *Commission v. France, Nord Pas de Calais,* [2000] ECR I-7445.

[35] Case C-324/98 *Telaustria* [2000] ECR I-745.

[36] Case C-231/03, *Coname*, [2005] ECR I-7287.

[37] Case C-458/03, *Parking Brixen*, [2005] ECR I-8612.

[38] Id. para 48.

[39] Case 234/03, *Contse*, [2005] ECR I-9315.

[40] OJ [2006] C 197/2.

a) contracts below the thresholds for the application of the Procurement Directives and b) contracts which are covered by the Directives but are listed in Annex II B of general procurement Directive and in Annex XVII B of the utilities Directive and are, thus, excluded from the technical procurement rules. Concession contracts and public-private partnerships (PPPs) are not covered by this Communication, as a larger consultation process is currently on its way, initiated by the Commission's White Paper of 2004, followed by a Communication of November 2005.[41] The *de minimis* Communication basically explains the way in which the principles set out by the Court's jurisprudence should be put to work. The four principles pursued are: a) non-discrimination (based on nationality) and equal treatment (also in purely national situations), b) transparency, c) proportionality and d) mutual recognition (hereinafter: the 'procurement principles'). According to the Communication, the obligations accruing for contracting entities under the general Treaty rules are proportionate to the interest that the contract at stake presents for parties in other member states. Four aspects of the award procedure are taken up by the Commission: advertising prior to the tender, content of the tender documents, publicity of the award decision and judicial protection. Without entering into the details of this Communication, it is worth making two remarks. First, from the four aspects treated by the Communication, all but the one relating to pre-contractual publicity are already regulated by the Public Procurement Directives for those service contracts (above the thresholds) which are included in Annex IIB (and XVIIB of the utilities Directive): the Procurement Directives themselves set minimal requirements concerning the technical specifications used in the tenders, as well as the publicity of the contract's award, while the 'procedures Directive' is fully applicable to these services. This first remark leads to the second one: since the legislator specifically decided to treat services included in the Annex IIB (and XVIIB of the utilities Directive) in a given way, is it politically admissible and legally sound, for the Commission to impose more stringent obligations through a text of soft law?

The Court has shown its great attachment to the general principles linked to public procurement in a second series of cases, a priori entirely foreign to award procedures. The most recent and most striking example is to be found in the Court's judgment in *Placanica,* a case concerning bet collection in Italy.[42] According to the Italian legislation this activity required a government licence from which undertakings quoted in the stock market (mostly non-Italian) were altogether excluded. The Court did not restrict itself to finding that such blanket exclusion was disproportionate to the objective of protecting consumers. It further stated that whenever operators have been unlawfully excluded from the award of licences (which were determinate in number) 'it is for the national legal order to lay down detailed procedural rules to ensure the protection of the rights which those operators derive by direct effect of Community law' and that 'appropriate courses of action could be the revocation and redistribution of the old licences or the award by *public tender* of an adequate number of new licences'.[43] This reflects an idea which is being implemented in the regulated industries (telecommunications, energy etc) and which had been put forward by the Commission (but never taken up) in a more general scale, concerning access to essential facilities:[44] whenever some scarce resource is to be distributed between competitors, the way to do it is through public tendering procedures.

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[41] COM (2005) 569 final, of 15.11.2005.

[42] Joined cases C-338/04, C-359/04 and C-360/04 *Placanica*, judgment of 6 March 2007, nyr.

[43] *Placanica,* rec. 63; italics applied.

[44] Report by the EC Commission in OECD/GD(96)113, available at http://www.olis.oecd.org/olis/1996doc.nsf/LinkTo/OCDE-GD(96)113 , p. 102.

Hence, not only the basic procurement principles (i.e. non discrimination and equal treatment, transparency, proportionality and mutual recognition) apply to all tenders involving public money, but also public tenders should be held in order for other (non financial) valuable resources to be put into the market; of course, these tenders also should abide by the basic principles governing public procurement.

Therefore, according to the latest case law of the Court, the basic principles governing public procurement (i.e. non discrimination and equal treatment, transparency, proportionality and mutual recognition) become a key regulatory instrument for the regulation of the internal market.

3. Applying the EC rules to national healthcare

Against this background the question arises if, how and to what extent the rules – or indeed the principles – on public procurement and those on state aids affect, or should affect the provision of healthcare in the member states.[45]

The organization of healthcare in all member states constitutes an expression of social solidarity. As such it shares some basic characteristics: it is intended to have universal coverage, it is publicly funded and entails cross-subsidization of risks (good risks financing bad ones) and patients (young and healthy patients financing the elderly and sick).

These main characteristics apart, healthcare systems in the member states are organized in a great variety of ways. In view of this great diversification, it is impossible to determine in an all-encompassing manner the way in which the EC rules on public procurement and on state aid affect the organization of healthcare in member states. This is why we thought useful to ground the present inquiry on specific member state case-studies and offer illustrations based thereupon.[46]

Since the rules on state aid on the one hand and on public procurement on the other, are so closely related and their application rests on the same sets of criteria, [47] in the analysis which follows we shall examine each individual criterion rather than the two sets of rules separately.

3.1 Where is the service of general interest?

The pursuance of general interest is a key criterion for qualifying a body as a ‘contracting entity’ in the sense of the Public Procurement Directives. At the same time it is the main condition for the application of the ‘compensation’ logic inaugurated with the Court’s judgment in *Altmark*.

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[45] For the first (and latest) official position on this issue see Commission Communication ‘Services of general interest, including social services of general interest: a new European commitment’, COM (2007) 725 final. This Communication comes in set with two ‘working documents’: SEC (2007) 1514 ‘FAQs concerning the application of public procurement rules to services of general interest’ and SEC (2007) 1516 ‘FAQs on the application of Article 86(2) to State aid in the form of public aid compensation’.

[46] Thanks to the valuable help of researchers and colleagues from the London School of Economics, the *Observatoire Social Européen* and other research institutes, some aspects of the healthcare systems of the following six member states are being discussed: England, the Netherlands, Belgium, Italy, Hungary and Greece. These are briefly depicted in the flow charts at the annex of the present Chapter.

[47] See above 2.1 and 2.2.

There is no doubt that providing healthcare for an entire population constitutes a service of general interest. This general assertion, however, is pregnant with ambiguities. Assuming that universal coverage of the population is an absolute aim (and hence the personal scope of the system is inelastic), there remain at least three variables in defining the scope of 'general interest' in the field of healthcare.

a) the kinds of treatments (and pharmaceuticals) provided by the system vary from one state to the other, according to religious, moral, scientific and other perceptions: cosmetic surgery, sex modification, pain treatment, abortions are just some examples where divergences exist between the various member states;

b) the quality of medical treatments provided may vary as a result of i) the qualification level of health professionals, ii) the number of health professionals, iii) the medical infrastructure of the hospitals (number and quality), iv) waiting time for having access to the system v) waiting time for receiving any given treatment etc;

c) the quality of the non-medical services, such as accommodation, catering, cleaning etc.

In most member states the level of healthcare which should be provided is described in one or more legislative acts (see e.g. the 1987 Hospital Act in Belgium, the 1977 NHS Act in the UK etc) or some other regulatory act (see e.g. the 2001 agreement between the Government, the Regions and the Provinces of Trento and Bolzano, for the application of the legislative decree 502/1992, in Italy). In some states a general provision securing a high level of healthcare to the population is also to be found in the Constitution (see e.g. article 70(D) of the Hungarian Constitution and in a less compelling formulation, Article 22 of the Dutch Constitution, Article 23 of the Italian Constitution, Article 23(3)2 of the Belgian Constitution, Article 21(3) of the Greek Constitution).[48]

These norms, however, even when they go beyond mere principles, they very rarely provide a detailed description of the above variables and, hence, fail to define the precise scope of general interest in healthcare. Next to these general rules, very specific and complex rules are to be found, concerning the calculation of various treatment units, the funding of the various parts of hospital budgets etc.[49] Usually however, these technical rules relate to the cost of specific activities, treatments etc and do not stand for the entire cost of services of general interest in healthcare.

Therefore, it would seem that the application of EC law would require the introduction, in the field of healthcare, of the concept of 'service of general interest' or 'public service' and a precise definition of its content. This would be necessary both

[48] It is worth noting that even in Hungary the constitution sets high requirements for the protection of health 'Article 70/D: (1) People living within the territory of the Republic of Hungary have the right to the highest possible level of physical and mental health. (2) The Republic of Hungary implements this right through arrangements for labour safety, with health institutions and medical care, through ensuring the possibility for regular physical training, and through the protection of the built-in a natural environment', the Constitutional Court of this country has decided that this is not an absolute and static right, but it should be interpreted within the economic and social context at any given moment; see in general about constitutionalism and social rights in Hungary, J.-J. Dethier & T. Shapiro, 'Constitutional Rigths and the Reform of Social Entitlements', available at http://www1.worldbank.org/wbiep/decentralization/library1/Dethier.pdf

[49] For which see above 3.2.2 and below, section 4.2.

for identifying with precision which entities are likely to qualify as 'contracting entities' and for applying the *Altmark* test. This should be done in a way more detailed than in the general constitutional or even legislative texts, but less technical than in the financial/accounting instruments. Four questions arise in this respect.

First, how detailed is detailed enough for the requirements of *Altmark* and the '*Altmark* Decision' to apply? In this respect the Belgian experience is interesting, yet by no means conclusive. After the '*Altmark* Decision' the Belgian Parliament added, in December 2006, a general clause to article 2 of the general 'Hospital Act' (loi du 7 août 1987). This clause formerly states that 'hospitals perform a task of general interest', in order for them to qualify for the funding possibilities opened up by the *Altmark* Decision. In its consultative opinion n. 41.594/3, the Belgian Council of State inquired whether such a simple modification could bring all hospitals within the scope of the 'compensation approach', since the other elements of the *Altmark* test were not specified: nature and duration of the services, territory concerned, calculation and justification of the charge required for the accomplishment of services of general interest. The Belgian Parliament, nonetheless, considered that all these elements could be adequately inferred from the legislation already in place and adopted the above modification.[50]

Second, the *Altmark* ruling entails a logical shift: while the national logic is one of defining the scope of a healthcare *system*, the EC logic is to define a *set of* healthcare *services* of general interest. This, in turn, may entail reassessing some of the assumptions concerning the provision of healthcare. For instance, all hospitals, public and private, offer various categories of hotel amenities. If rooms with three or more patients may reasonably qualify as services of general interest, the same may not be true for single or even double rooms, except where this is justified by medical reasons.[51]

Third, and in direct relationship with the previous point, are member states free to fix the outer limits of 'services of general interest'? The Commission in its *Altmark* package states that it will only interfere in cases of 'manifest error'.[52] This view finds support in the case law of the Court. In this respect it may be useful to compare the two judgments of the Court concerning ambulance services. In the Austrian *Tögel* case the Court reasoned on the basis that any award of ambulance transport contracts should be made according to the 'services' Directive 92/50/CE, provided that this text had become binding at the relevant date (which was not the case for Austria). In the German *Glöckner* case, on the other hand, the Court admitted that ambulance contracts could be awarded on the basis of a prior authorisation, with no tendering procedure. This was so because, a) reasonably priced urgent services with a large territorial coverage constituted a service of general interest, and b) other transport services, although not directly linked with the general interest, served to finance the former. Hence, in *Glöckner*, despite the precedent set by *Tögel,* the Court was not willing to interfere with the German definition of services of general interest and the way they are financed. If member states enjoy a wide discretion in extending the scope of services of general interest, the same is not true when it comes to lowering the standards of care - although the limits to their discretion are of an

[50] See the explanatory memorandum of the proposal in the Belgian Chamber of representatives, http://www.dekamer.be/FLWB/pdf/51/2760/51K2760001.pdf.

[51] In some states such a distinction is already made, e.g. in Belgium, both hospitals and practitioners may charge supplements to patients staying in single or double rooms; for double rooms dwellers there is a cap at the supplements charged, while for those living in single rooms .

[52] See Decision rec. 7 and Community Framework rec. 9.

indirect nature. Hence, in *Vanbraekel* the Court said that the authorities of a member state, if they do not offer a treatment themselves, may not refuse to refund it only by reference to national standards and practices, if obtained in another member state. Similarly, in *Müller-Fauré* the Court held that if national waiting lists are far too long for the medical condition of any individual patient, then he/she should be entitled to receive treatment in another member state.

Fourth, a more radical idea may be put forward:[53] it may be that hospitals do not offer public services at all. According to this analysis, the service of general interest resides in assuring universal coverage and adequate funding for healthcare - healthcare itself may be purchased at any time, at the right price. Then, only the funds would be performing some task of general economic interest. However, in view of the preceding paragraphs and of the fact that the '*Altmark* Decision' holds legitimate any aid given to hospitals for the fulfilment of public service obligations, this radical analysis is not likely to be widely followed any time soon.

3.2 How is it financed?

The definition of the scope of healthcare services of general interest is intrinsically linked to the question of financing these same services. In this respect several remarks should be made.

3.2.1 Distinguishing capital costs from exploitation costs

In most member states (all those studied in the present) there is a more or less clear distinction between, on the one hand, capital investment, infrastructure etc and, on the other hand, exploitation.[54] Two remarks should be made in this respect.

First, this choice spontaneously made by member states corresponds to the model chosen by the EC legislature for the development of another field where infrastructures occupy a very important role: rail transport.[55] This distinction, however, has proven difficult to implement in the rail sector, even where clear rules of accounting unbundling did exist. This has led the EC legislator in the field of rail transport to require the organic separation of entities dealing with infrastructure from those offering services.[56] Hence, it remains to be ascertained, at a state by state level, how this distinction works for healthcare. Further, an important difference exists between rail and hospital infrastructure, both developed with public money: the former may be hired out to competitors of its holder, while the same is not true for the latter. Therefore, the direct financing of infrastructure by the public purse may affect competition both at the level of hospitals (public/private or between member states) and at the level of insurance funds. The Belgian experience is instructive in this respect. In Belgium hospital infrastructure is financed at 40% by the Federal Ministry of health, while the remaining 60% by the Communities. When Belgian hospitals conclude contracts with Dutch health insurers, they charge the same tariffs to those

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[53] See e.g. G. Chavrier, 'Etablissement public de santé, logique économique et droit de la concurrence' in (2006) *Revue du Droit de la Sécurité Sociale*, 274-287.

[54] In the Netherlands, however, this will change as of 2008: while today capital costs are not included in the total sum hospitals can claim from the contracted health insurers, from 2008 part of capital costs will be negotiable (between hospitals and insurers) and included in the DRGs

[55] See Directive 91/440/EEC of the Council, for the development of community rail, OJ [1991] L 237/25, Art. 6.

[56] See Directive 2001/12/EC of the EP and the Council, modifying Directive 91/440, OJ [2001] L 75/1, art. 6 para. 2.

as they do to the Belgian health insurance system. This means that investment cost for hospitals is only charged for 40 %. Some Dutch hospitals do perceive this as a distortion of competition and a Dutch organisation of hospitals voiced that they do consider this as not permitted state aid in favour of the Belgian hospitals.[57] It is difficult, however, to see how such a distortion could be remedied. The 40-60 funding, linked to the federal structure of the state and embodying important political choices, may not be put directly into question by the rules on state aids (provided that transparency is ensured). On the other hand, it does not seem possible for Belgian hospitals to charge insurers differently, depending on their state of establishment.

Second, infrastructures and other fixed costs have traditionally been financed directly by the public purse, but in recent years some states try to attract private investment. The Private Funding Initiative (PFI) in the UK has set the pace and other countries have followed suit. The emergence of new contractual forms, such as PPPs and concessions offer further means of bringing in private funds. These may not be examined in the present chapter, but one remark should, nonetheless, be made: the choice of private investors who will participate in the capital of public hospitals (like in other public infrastructures) may only be made following the 'public procurement principles'.[58]

3.2.2 Calculating the cost of public service

Hospitals' budgets have very complicated structures and vary from one state to another. A point in common is that, next to capital investment cost (for which see the previous paragraph) they distinguish, a) fixed costs, such as maintenance, heating, personnel etc and b) variable costs, directly linked to the volume of their activity. The way to calculate this latter segment of expenses has been reviewed in most member states during the last years. In order to create incentives to contain cost and rationalise treatments, three main directions have been followed: a) advance payments of prospective budgets based on average costs of hospitals of the same category, b) calculation of the average costs on the basis of DRG or equivalent measuring unit,[59] only occasionally completed or adjusted by the application of fee-for-service or length-of-stay criteria, c) the possibility for efficient hospitals to keep any surplus. Not only do these measures force the hospitals to a more sound management of financial resources, but they also dramatically increase transparency. By the same token, the *Altmark* requirement of calculating the precise cost of public service is likely to be satisfied.

Transparency and cost calculation is also served by the fact that in all the member states examined, practitioners are mainly self-employed (with the exception of Hungary, where the only considerable category of self-employed practitioners are family doctors) and enter into contracts with hospitals or funds. An issue here is the way that physicians' fees are fixed: it would seem that a system of public tendering like the Italian one, would be preferable to, say, the Belgian one, where fees are fixed under the auspices of the public fund (INAMI) and may or may not be adhered into by

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[57] I. Glinos, N. Boffin & R. Baeten (2005). Cross-border Care in Belgian Hospitals: An Analysis of Belgian, Dutch and English Stakeholder Perspectives (pp. 89). Brussels: Observatoire Social Europeen, p. 66

[58] See above, 2.3.

[59] Diagnoses Related Groups (DRGs) or equivalent measuring units (Diagnose Behandelings Combianties, DBCs in the Netherlands, Healthcare Resource Groups, HRGs in England). DRGs are pre-defined pairs, whereby each specific medical condition is matched up with a determined treatment and/or length-of-stay.

each individual physician.[60] This is so for three reasons. First, because price fixing by public authorities and/or professional organisations may be foul of either the competition or the internal market rules, or both. Second, because, the prices obtained through public tendering are more likely to reflect market price in any given geographic area. Third, because if the award criterion is not only price but also quality, then better qualified physicians would obtain better contracts. A different – but linked – issue is that of the price public hospitals should charge practitioners, for use of the hospital infrastructure in order to offer 'for fee' healthcare services, outside the health system. In this respect an extremely recent judgment of the French Council of State clearly illustrates the strain public health systems are going through:[61] in the face of well-established legislation and jurisprudence which allowed only for the payment of a flat 'occupancy fee' for the facilities, the Council of State admitted that the actual economic value of the service may be mirrored in the fee the practitioner is made to pay to the hospital. This evolution under French law reflects the divergences subsisting in the other member states: in England practitioners retain a portion of the revenues privately realised before feeding the rest back to the NHS, while in Belgium the situation is closer to the one traditionally prevailing in France, whereby a mere 'droit d'usage' is charged.

A further point in assessing the transparency of the way the cost of public service is calculated relates to the number of the intermediaries involved. The more diverse the routes for public moneys to reach hospitals and/or funds, the less transparency there will be. An illustration may be offered by the Hungarian system, where public hospitals a) receive funding for their infrastructure directly from the Ministry of health, b) while for their services they receive money from the Health Insurance Fund, which (money) however is mediated either through (large) municipalities or through local governments, or both. Moreover, the mediation of the Fund's money through local authorities, both in Hungary and in Italy, may result in political choices altering knowledgeable economic calculations. Hence, the calculation of the cost of public service may be flawed, thus making the application of the public procurement and/or state aids law more likely.

Calculating the cost of public service is directly linked to the way this is financed.

3.2.3 Funding the cost of services of general interest

According to the '*Altmark* Decision' 2005/842/EC of the Commission, state aid given to hospitals for the accomplishment of public service obligations entrusted to them is exempt of notification and automatically legal, irrespective of the amount. Aid awarded to hospitals, however, need be strictly measured on the accomplishment of public service. Several questions arise in this respect.

First, it is not clear what should happen if hospitals fail to accomplish their mission of general interest and who would be qualified to ascertain such failure – it may be that

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[60] The Court is not particularly keen in price-fixing by professional associations and other bodies, see recently Joined Cases C-94/04 & 202/04, *Cipolla e.a.* [2006] ECR I-11421. See also, at the national level, a settlement reached before the Irish Competition Authority on May 25, 2007, whereby the Irish Medical Organisation, an association of GPs in Ireland, has undertaken not to take action in relation to prices in respect of several of their activities; the settlement is reported and briefly commented by O. Lynskey in e-Competitions e-bulletin, August 2007-II, n. 14004 and by C. Hatton & S.A. Kauranen in e-Competitions e-bulletin, July 2007-II, n. 13967.

[61] CE 16 juillet 2007, Syndicat National de Défense de l'Exercice Libéral de la Médecine à l'Hôpital e.a. n. 293229; for this case see briefly B. du Marais and A. Sakon (4/2007) *Concurrences* p. 148-150

some system of monitoring should be set up as a consequence of the *Altmark* requirements.[62] Indeed, *second*, such a monitoring system seems to be required in order to control overcompensation. *Third*, under the Decision, overcompensation is explicitly ruled out and need be paid back, subject to a margin of 10% which may be carried forward to the next year. Hence the system of efficient hospitals 'keeping the surplus' of their annual budget introduced in some states as an incitement for efficient management[63] should be revised in light of the above. *Fourth*, while the *Altmark* package allows for some reasonable profit to be made by the provider of services of general interest, it is not clear whether and how this should materialise in the hospital sector.

The above apply to moneys given to hospitals directly by the state budget (e.g. in England),[64] or by public insurance funds or funds where membership is compulsory (e.g. in Italy, Hungary, Belgium, and Greece).[65],[66] It is unclear whether the same principles apply to a system like the Dutch, where private insurers compete with one another for patients (but are under an obligation to admit everyone) and hospitals compete for contracts with as many insurers as possible. In other words, it is not clear whether 'public' moneys are involved. On the one hand, the presence of market forces and freely negotiated contracts would point to a negative answer. On the other hand, the fact that membership to some fund is compulsory may lead to a positive answer.[67] If the former solution were retained and no 'public' moneys were involved,

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[62] It would seem that Decision 2005/842/EC does require some monitoring, especially to overlook overcompensation, see art. 4(d).

[63] Such a system was introduced e.g. in Belgium in 2001: the overall available budget is divided over five groups of hospitals on the basis of percentage shares, which are determined a priori for the different types of costs and hospital groups. Each hospital is allocated the same average cost per work unit of the group to which it belongs. Objectively observable and justifiable cost differences, such as labour costs, are taken into account. Hospitals that manage their communal services more efficiently than the group average are allowed to release financial resources that can be used for other purposes. In England, a funding scheme adopted in 2002 but gradually phased in between 2004-2009, follows a similar pattern: The Department of Health (DoH) sets national tariffs for Healthcare Resource Groups (HRG), similar to DRGs. The national tariff is adjusted by a Market Forces Factor to account for unavoidable differences in costs across regions. Providers who deliver services at a cost below the tariff prices will retain the surplus. However, the new funding scheme is intended to create competition on quality of services and efficiency (waiting times) rather than price.

[64] The Department of Health (DoH) gives tax money to the Primary Care Trusts (PCTs), which in turn contract in public and private hospitals and General Practitioners (GPs) – see the relevant flowchart in the annex.

[65] In Italy a National Health Fund gives money to the Municipalities and the Local Health Authorities (ASL), which in turn contract in (or set up their own) public and private hospitals and GPs – the system is very much like the English one with the difference that it is not based on tax but on contributions; similar to the Italian is the system in Hungary, with the difference that no equivalent of the independent Local Health Authorities exists; in Belgium the INAMI/RIVIZ (and some mutuelles covering a one-digit share of the population) buy directly services from public and private hospitals; similar is the situation in Greece, with the difference that there is not a single, but several funds. For all the above see the flowcharts in the annex.

[66] See for an example where a state aid was given by the Belgian pension fund ONSS (which is the INAMI equivalent in the field of pensions) to a private undertaking, in the form of payment facilities Case C-256/97 *Déménagements-Manutention Transport SA (DMT)* [1999] ECR I-3913; see also Case C-75/97 *Belgium v Commission, Maribel*, [1999] ECR I-3671.

[67] It is reminded that in another context, in *Maribel*, above, Rec. 23, as well as in Case C-200/97 *Ecotrade* [1998] ECR I-7907, Rec. 34 the Court has held that 'measures which, in

then payments from health funds to hospitals would not qualify as state aids at all and could only be scrutinised under Articles 81 and 82 EC. If, on the other hand, funds did qualify as 'public', then the Dutch system would be no different from the other member states examined.

3.3 Who is a contracting entity – who is an undertaking?

In the analysis above it has been put forward that any given entity should qualify either as a contracting entity or as an undertaking and that the two qualifications should be mutually exclusive. The criterion for determining when an entity qualifies as an undertaking is as broad as 'the exercise of an economic activity'.[68] On the other hand, a contracting entity is one which 'does not pursue an activity of economic or commercial nature'.[69] What is more, one of the fundamental principles of market economy is that operators may contract with whomever they wish:[70] any given entity may not be subject simultaneously to free competition and to the restrictive and time consuming rules on public procurement.[71] This however is not necessarily true in a hybrid economic sector, such as the provision of healthcare. Possibly more controversial than the technical issues above, is the more general question of whether healthcare provision should be subject to the procurement rules at all. In this respect, a) the lack of flexibility of the procurement rules, especially in respect of the role of non profit social organisations, b) the transformation of partnership relationships into competitive ones, c) the restriction of cooperation between local authorities, resulting from the restrictive concept of 'in-house contracting' followed by the EC, d) the negative effect on establishing long-term trust relationships with suppliers and other partners, e) the possible disruption of the continuity of public service, f) increased transaction costs and g) delay, are just some of the arguments put forward against the general application of public procurement rules in the core of health provision.[72] Most of these concerns are being dealt with – although not really answered – by the Commission in its most recent Communication on Services of General Interest and the accompanying documents.[73] In these texts the Commission confirms its attachment to the application of the public procurement rules and principles.

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various forms, mitigate the charges which are normally included in the budget of an undertaking and which, without therefore being subsidies in the strict meaning of the word, are similar in character and have the same effect are considered to constitute aid'.

[68] See O. Odudu *The Boundaries of EC Competition Law* (2006) OUP Oxford, p. 26-45.

[69] See S. Arrowsmith and C. Bovis, above n. 16.

[70] This 'freedom to deal' is known in competition law as the 'Colgate doctrine' from the US Supreme's Court judgment in *United States v. Colgate & Co.*, 250 U.S. 300 (1919).

[71] See above 2.2.

[72] See e.g. EC Commission 'Social Services of General Interest: Feedback Report to the 2006 questionnaire of the Social Protection Committee' available at http://ec.europa.eu/employment_social/social_protection/docs/feedback_report_en.pdf p. 10-12; see also (on an earlier set of replies from the member states) M. Maucher in 'Analysis of the replies of all European Union member states' governments to the questionnaire of the Social Protection Committee preparing the Communication on Social and Health Services of General Interest' (2005) available at http://www.soziale-dienste-in-europa.de/Anlage25573/auswertung-antworten-ms-mitteilung-sgdai-ed.pdf.

[73] See Commission Communication 'Services of general interest, including social services of general interest: a new European commitment', COM (2007) 725 final and the accompanying "working document" SEC (2007) 1514 "FAQs concerning the application of public procurement rules to services of general interest"

3.3.1 Contracting entities: some certainty?

In Annex III of Directive 2004/18 member states have enumerated, in a non exhaustive manner, the entities which they deem subject to the procurement rules.

- Belgium considers the INAMI (along with many other funds) to be a contracting entity, as well as three hospital centres owned by the central government.[74] The fact that the remaining 63 public hospitals (run by the Communities) are not included in the annex only means that their qualification as a contracting entity is not automatic.

- Italy enumerates indistinctively all bodies administering compulsory social security and welfare schemes and a general category of 'organisations providing services in the general interest'. This presumably covers hospitals owned by the Local Health Authorities (ASLs) as well as public hospitals. It is less clear whether hospitals having the status of trust are also covered, although the most likely answer is positive.

- Greece gives only general definitions which clearly encompass all public healthcare funds and all hospitals where the state owns more than 51% stock or finances at least 50% of the annual budget (=all public hospitals)

- The Netherlands enumerate several bodies involved in the management of hospital facilities, accreditation of health providers etc, but neither funds nor hospitals as such. Since funds are free to contract with any care provider of their choice, it would seem illogical to hold them to the procurement rules.

- The UK enumerates the NHS Strategic Health Authorities (SHAs), who are the entities responsible for the attainment of the health targets decided by the Secretary of State for Health. However, under the current design of the NHS the largest part of contracting is not done by the SHAs but by the Primary Care Trusts (PCTs). In 2000 the NHS Purchasing and Supply Agency (PASA) was set up as an executive agency of the Department of Health and was entrusted to centralise and carry out procurement on behalf of all NHS entities.

- Hungary, like the other nine new member states who acceded in 2004, has not made any declaration under annex III of Directive 2004/18 (it is worth noting that Bulgaria and Romania have done so).[75] However, it makes no doubt that public hospitals, to the extent that they are financed by the Ministry of Health and by the Health Insurance Fund, through the local authorities, are themselves contracting entities.

[74] The majority of hospitals in Belgium are private hospitals (151 out of 215, equal to 70%, in 2005). Most private hospitals are owned by religious charitable orders, while the remaining is owned by universities or sickness funds. Public hospitals are for the most part owned by a municipality, a province, a community or an inter-municipal association (which is a legal form of association that groups together local authorities, public welfare centres and, in some cases, the provincial government or private shareholders). Both private and public hospitals are non-profit organizations. Hospital legislation and financing mechanisms are the same for both the public and private sectors

[75] See Directive 2006/97/EC, OJ [2006] L 363/107.

From the above listing it becomes clear that even in public procurement, an area where substantial harmonisation has been taking place for over twenty years now and where member states are supposed to be on the same wavelength, common solutions are non existent. It also becomes clear that member states have no shared views about the role the various entities play in their respective healthcare systems.

3.3.2. Undertakings everywhere?

There is no doubt that self-employed physicians, even when they are contracted in a national healthcare scheme or in a hospital, are undertakings.[76] On the opposite, doctors who are public employees (as it is, for instance, the case for the vast majority in Hungary) are not.

The position of insurance funds is more complex. A very broad distinction may be drawn between funds where membership is compulsory, and those offering complementary cover: the former would not qualify as undertakings while the latter would. The reason is that in the former, the state's intervention, in order to secure the objective of 'universal minimum cover', may be such that their commercial freedom be jeopardised. Hence, e.g. Regulatory measures in Germany and (prior to 2006) in the Netherlands imposed on private insurers 'the provision of lifetime cover, the introduction of policies with mandatory pooling, standardized minimum benefits, guaranteed prices and the establishment of direct or indirect cross subsidies from those with private to those with statutory coverage. In contrast, regulation of most markets for complementary and supplementary cover tends to focus on *ex post* scrutiny of financial returns on business to ensure that insurers remain solvent.'[77] However, this is a simplistic distinction and may be misleading: private funds offering 'complementary' cover account for an increasing portion of the market (10-20% of total health expenditure in the EU) and tend to be increasingly regulated by member states, in a way that their qualification as 'undertakings' may be put into question.

There is no hard and fast rule for determining whether an insurance fund qualifies as an undertaking, rather, as noted above, the Court refers to a set of criteria (faisceau d'indices). From a relatively long series of judgments,[78] it follows that elements which would point to a non-market entity, include:[79] a) the social objective pursued, b) the compulsory nature of the scheme, c) contributions paid being related to the income of the insured person, not to the nature of the risk covered, d) benefits accruing to insured persons not being directly linked to contributions paid by them, e) benefits and contributions being determined under the control or the supervision of the state, f) strong overall state control, g) the fact that funds collected are not capitalized and/or invested, but merely redistributed among participants in the scheme, i) cross-

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[76] Joined Cases C-180-184/98 *Pavlov a.o.* [2000] ECR I-6451.

[77] For this excerpt and for the critique which follows see S. Thomson & E. Mossialos 'Regulating Private Health Insurance in the EU: The implications of Single Market Legislation and Competition Policy' (2007) *European Integration,* vol. 29, 89-107, 93-94.

[78] See Case C-238/94, *FFSA*, [1995] ECR I-4013; Case C-70/905, *Sodemare*, [1997] ECR I-3395; Case C-67/96, *Albany*, [1999] ECR I-5751; Joint Cases C-155/97 and C-157/97, *Brentjens*, [1999] ECR I-6025; and Case C-219/97, *Drijvende*, [1999] ECR I-6121, respectively. On these three cases, see Idot, "Droit Social et droit de la concurrence: confrontation ou cohabitation (A propos de quelques développements récents)", (1999) *Europe,* chron. 11; Case C-218/00, *Batistello*, [2002] ECR I-691; Case T-319/99, *FENIN v. Commission*, [2003] ECR II-357 upheld by the Court in Case C-205/03P *FENIN* [2006] ECR I-6295; Case C-355/00 *Freskot v. Elliniko Dimosio* [2003] ECR I-5263; joined Cases C-264/01, C-306/01, C-354/01 and C-355/01, *AOK Bundesverband*, [2004] I-2493.

[79] Note that these are broadly the same – but from the reverse side – as the ones used to identify contracting entities, see above n. 16 and the relevant text.

subsidization between different schemes and j) the non-existence of competitive schemes offered by private operators.[80]

In this respect, the judgment in *FENIN* should be singled out,[81] not least because the Court, in appeal proceedings from the Court of First Instance, confirmed that an entity which purchases goods (or services) not in order to resell them in the market, but in view of accomplishing some essentially social task, is not an undertaking.[82] This, however, has not prevented the Polish competition Office for Competition and Consumer Protection, in a Decision of March 2007,[83] to condemn the National Health Fund, whose task is to ensure health services to the insured persons (a traditional public authority task), for abusing of its dominant position (!) by fixing below-cost contracting prices for dentists.

On the other end of the spectrum, on the basis of the *FENIN* reasoning, it would seem that public hospitals securing adequate treatment to the individual patients, typically free of charge, do not qualify as undertakings. This logic however, is being put into question by at least two developments. First, in its *Altmark* Decision the Commission, admits that moneys given to hospitals (irrespective of ownership) for fulfilling their public service obligations qualify as aid, albeit justified. This, in turn, implies that hospitals are undertakings. Second, the German *Bundeskartellamt* (possibly the most influential national competition authority in the EU), in a Decision of March 2005, has blocked a merger between two public hospitals; hence it has considered them to be undertakings subject to the merger control.[84] Although this decision of the German competition authority is in line with its previous law concerning utilities,[85] one may object that the utilities sector has been heavily regulated for more than twenty years now, both at the level of procurement and at the level of deregulation/re-regulation, and that comparing healthcare with the other utilities sector, at this stage of community law, is materially inappropriate and legally not conclusive.

It is, therefore, difficult to foresee when a public hospital will be held to constitute an undertaking. It would seem that criteria such as a) an independent board of directors, b) a relative flexibility in the execution of the budget, c) contractual freedom, d) a relatively developed side activity of a commercial nature etc are likely to make a

[80] For a more detailed analysis of those criteria, see V. Hatzopoulos 'Health Law and Policy…', above n. 1, p. 123-160; For a critical view of the Court's meddling with social funds, see also Kessler, 'Droit de la concurrence et régimes de protection sociale : un bilan provisoire', in R. Kovar & D. Simon, *Service public et Communauté Européenne: entre l'intérêt général et le marché*, vol. I, La documentation française (1998) 421 at 430, where reference to other critical commentators.

[81] Cited in the previous note.

[82] See M. Krajewski & M. Farley, 'Non economic Activities in Upstream Markets and the Scope of Competition Law after FENIN' (2007) ELRev 111-124.

[83] Decision n DOK 28/2007, of March 7, 2007, concerning practices of the National Health Fund, reported and commented by J. Farrugia and by M. Tomaszefska in E-Competitions Law Bulletin, May 2007-II n. 13629.

[84] Bundeskartellamt, 23 March 2005, Rhön-Klinikum AG, Landkreis Rhön-Grabfeld, Decision B10 -
123/04, reported and commented by H. Bergmann and F. Röhling in E-Competitions Law Bulletin, January 2007-II n. 12733.

[85] This statement is taken from the above commentary.

public hospital qualify as an undertaking.[86] Hence, hospitals having the form of a trust, in England and in Italy, are likely to qualify as undertakings.

3.3.3 Undertakings subject to the procurement rules?

From the two previous paragraphs it becomes clear that a) it is very difficult to know which entities, in the field of healthcare, qualify as contracting entities and b) entities which some years ago were thought of as completely evading the market rules are increasingly treated as undertakings, at the EU and at the national level alike. What is more, these imprecise categories often overlap. We saw that many member states (such as Belgium, Greece, Italy) have included in Annex III of the Procurement Directive healthcare funds, many of which would qualify as undertakings under the criteria set by the Court. At the same time most public hospitals do currently follow some procurement rules, at least for purchasing goods (this is the case e.g. in England, through the PASA, in Greece, in Hungary).[87] In Belgium even private hospitals are subject to public procurement rules (at least for construction and heavy equipment), since they receive 60% of their capital investment budget from the Communities. At the same time private hospitals and, probably, many public, would qualify as undertakings. This is not a satisfying situation, for the reasons explained above in 2.1 and 2.2. As it will be explained in 3.4, below, for an entity involved in healthcare, it is much less constraining to be qualified as a contracting entity rather than as an undertaking. The latter qualification becomes even more problematic in view of the recent 'decentralisation' of the application of EC competition law introduced by Regulation (EC) 1/2003,[88] as it may lead to very divergent solutions, especially concerning borderline hospitals. In this respect, Decision 2005/842/EC (the *Altmark* decision) is a positive step, since it clears hospitals, irrespective of their qualification as undertakings, from the application of the state aids rules. It may be that a similar 'block exemption' could also clarify the position of hospitals under Article 81 EC. However, no advance clearance from the application of Article 82 may be given and, indeed, the invocation of abuses against hospitals is a likely scenario. A possible solution to this problem could lie in adapting the system of the Utilities Procurement Directive (2004/17/EC) in the healthcare field: require member states to dress a complete list of all the entities considered as contracting entities (thus evading their being qualified as undertakings) and foresee a mechanism for the regular revision of this list, similar to Article 30 of the Directive, accounting for market developments and the introduction of competition.

3.4 What kind of award procedures should be followed?

When an entity in the field of healthcare qualifies as a 'contracting entity' in the sense of the Procurement Directives, its obligation to run competitive tenders is not an absolute one. There are limitations stemming both from the nature of the award (completely closed or completely open) and from the nature of services (healthcare, included in Annex III of the Procurement Directive). Four cases may be distinguished.

[86] This may be counter-productive, to the extent that member states may be inclined to resist any of the above economically sound measures just in view of evading the Treaty competition rules.

[87] Greece has had infringement procedure initiated against it by the Commission for the technical specifications used in several tendering documents for the supply of medical devices, see *Agence Europe* 29/6/2006.

[88] Council Regulation (EC) No 1/2003 of 16 December 2002 on the implementation of the rules on competition laid down in Articles 81 and 82 of the Treaty, OJ [2003] L 1/1.

3.4.1 No contractual relationship

In some healthcare systems, the public authority responsible for delivering care set up and run their own treatment facilities, in the form of treatment centres, small hospitals or clinics. Such is the case, for example of the Local Health Authorities (ASLs) in Italy or the Primary Care Trusts (PCTs) in England; also some funds in Greece do the same. The Court has held that an award procedure is only necessary when a *contract* is to be entered into – and that no entity can contract with itself. If services are provided between two bodies belonging to the same public entity, we are in the presence of 'in-house provision' of services.[89] In-house is any service provision offered between bodies with no separate legal personality. In the presence of distinct legal entities, in-house provision only exists where two conditions are fulfilled, in a cumulative manner:[90] a) the procuring entity should exercise over the supplying entity 'a control which is similar to that which it exercises over its own departments' and b) the supplying entity should carry out 'the essential part of its activities' with the procuring entity. While the latter condition will rarely be a problem in the case of hospitals etc created by public authorities or funds, the former may prove problematic and counter productive in the future. In a highly contested judgment, the Court has held that private participation in the shareholding of a public company, even at a percentage of 0,02%, may disturb the 'similar control' of the local authority which controls the remaining 99,98%, unless such authority holds special privileges by virtue of the companies constitution. This may discourage public hospitals from seeking private investors or, conversely, investors to give money to entities in which the public authorities have privileges.[91] Both in England and in Italy private funding initiatives for public hospitals are under way. Hence, in-house provision will be increasingly unlikely. If, notwithstanding, the relationship is found to be 'in-house' then no award procedure is necessary.

The same is true for systems like the Hungarian and the Greek, where all public hospitals cooperate, by law, with all public funds.

In all these cases the qualification of a body as a contracting entity has legal consequences only when the entities concerned purchase extra capacity, outside their own 'production'.

3.4.2 Closed awards

In some cases member states may wish to confer an exclusive or special right to one or several undertakings. Instituting such rights is not forbidden by the Treaty rules, especially if such rights are linked to the provision of some service of general interest. This link may be direct (i.e. the service over which a special right is conferred is itself a service of general interest) or indirect (i.e. the service over which a special right is conferred is used to finance a contiguous service of general

[89] See in general, S. Arrowsmith, above n. paras. 6.196-6.193. Also, M. Giorello, 'Gestions *in house*, entreprises publiques et marchés publics : la CJCE au croisement des chemins du marché intérieur et des services d'intérêt économique général' (2006) RDUE 23-50.

[90] Case C-107/98 *Teckal* [1999] ECR I-8121.

[91] In this respect the 'golden shares' case law becomes relevant, where the Court condemned member states for instituting shares with increased voting (or other rights) while opening up their utilities companies to private markets; see e.g. Case C-367/98 *Commission v. Portugal* [2002] ECR I-4731; Case C-483/99 *Commission v. France* [2002] ECR I-4781; Case C-503/99 *Commission v. Belgium* [2002] ECR I-4809; Case 463/00 *Commission v Spain* [2003] ECR I-4581.

interest).[92] The Procurement Directives are not applicable to the award of such contracts,[93] but the general Treaty rules are. This means that, as the law stands at present, if new rights were to be awarded, this should be done according to the 'procurement principles' highlighted above in 2.3. If, however, the new award is only necessary in order to extend pre-existing exclusive or special rights, it may be that the selection may operate without a public tender. This seems to be stemming from the Court's judgment in *Glöckner,*[94] where the Court admitted that extending the duration of previous special rights for ambulance and transport services did not require a tendering procedure. This bit of the Court's judgment, however, is very laconic and obscure and may have been overturned by the more recent and more peremptory judgment in *Placanica*.[95] It is reminded that in this case the Court held that even the revocation and re-distribution, by public tender, of authorisations may be required in order to make it up for the violation of the Treaty rules. Hence, it is not clear whether 'closed processes' are allowed and under which circumstances.

3.4.3 Open awards

On the opposite end, in many occasions member states award contracts not on the basis of a competitive tender, but upon the fulfilment of several criteria set in advance. In the field of healthcare this practice is quite wide-spread, since in many member states all physicians and/or all hospitals that fulfil several criteria may be contracted-in in the public healthcare system. This is true for physicians in Belgium, Hungary, Greece, the UK and also (subject to advance planning) for hospitals in Belgium.

In this case the award procedure has the characteristics of the delivery of an administrative authorisation, since everyone who fulfils the conditions set in advance should be awarded a contract. Hence, the case law of the Court on the delivery of authorisations becomes relevant: the conditions for their delivery should be objective, transparent and non-discriminatory and known in advance, while the procedure should take a reasonable time and be subject to judicial review.[96]

3.4.4 Competitive awards

Finally, there are cases where a proper competitive tender is to be held. This is what should happen in Italy, the UK, Hungary and Greece, when the relevant public authorities or Trusts need to contract in hospitals and doctors – on top of the ones directly run and/or financed by them.

In this case, the Public Procurement Directive (2004/18/EC) should be applied. It is reminded that 'health and social services' are enumerated in Annex II B of the Directive and are only subject to a partial application of its rules. The only Directive provisions which are applicable to the Annex II B services are Article 23, on the technical specifications to be used in the tender documents and Article 35(4) on the publication of an award notice.[97] For the rest the contracting entity is free to follow

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[92] See Case C-320/91, *Corbeau*, [1993] ECR I-2562; Case C-393/92, *Almelo*, [1994] ECR I-1477and Case C-475/99, *Glöckner*, [2001] ECR I-8089.

[93] Directive 2004/18/EC Art. 18.

[94] Above n. 82.

[95] Above n. 42.

[96] See, among many, *Smits &Peerbooms, Vanbraekel* quoted at n. 1.

[97] Directive 2004/18 Art. 21. Mixed contracts, (which involve the provision of both healthcare and other, Annex II A services) should be awarded on the basis of the contract having the most important value, *ibid* Art. 22; see also the Court's judgment in *Glöckner.*

the award procedure of its choice … provided this satisfies the general 'procurement criteria' recognised by the Court: non-discrimination and equal treatment, transparency, proportionality and mutual recognition. Therefore, the freedom left by the EC legislature in favour of entities operating i.a. in the health sector is seriously circumscribed by the recent case law of the Court. As explained above, this requires adequate publicity, extended mutual recognition and, most importantly, does not allow for clauses which would exclude directly or indirectly, operators from other member states. The Commission's 'Framework' Communication of the *Altmark* package, clarifies the above requirements and further restricts the freedom of action of the contracting entities. The doubts, expressed above, as to whether this 'Framework' could and should affect the procurement practices of healthcare entities, remain to be tested before the national courts and, ultimately, the ECJ.

4. Conclusion

National healthcare systems embody the principle of solidarity and require public moneys, alone or together with private investment. In either case, and depending on the public/private mix, these resources may not reach the 'market' for healthcare services in an arbitrary way, but should be channelled through the Treaty rules on state aids and/or on public procurement.

Healthcare systems in most member states are in a transition, whereby public and private coexist: private investors are increasingly involved, as state funding becomes scarce; in the meantime, hospitals develop advanced accounting methods and managerial independence. This transition, pregnant with political, economic and legal uncertainties, explains the malaise in applying the EC rules. Rules which are designed to regulate different situations and which, according to the recent case law of the Court, are linked through a logic of mutual exclusion, are tangled into unforeseen legal combinations. Qualifying entities involved in the provision of healthcare as undertakings and/or as contracting entities is an exercise where legal sophistication and imagination go hand in hand. The current situation is far from securing legal certainty or even, predictability.

In a previous article we had put forward the idea that 'entities caught by the rules on competition should unequivocally be exempted from observance of the rules on public procurement, while some guidelines should be drawn in order to avoid a rigid and counter-productive application of the rules on state aids on the organization and functioning of national healthcare systems'.[98] After some hesitation the Court in *Altmark* and the Commission in the *Altmark* package have tried to disentangle some of the skein, by exempting hospitals from the rules on state aids, under given circumstances. However, the *Altmark* conditions are too demanding and, in practice, very rarely fulfilled. Further action may be required by the Commission, in the form of a block exemption regulation from Article 81 EC for healthcare providers. Member states could themselves ease the application of the Treaty rules by setting out clearly which of the entities involved in the provision of healthcare they deem to be undertakings and which ones are contracting entities; this list should be regularly updated. Even if all this were to happen, the legal situation would still be complicated, reflecting the material differences of the national healthcare systems.

How deeply the EC rules on public procurement and on state aid are going to affect the organisation of national health systems cannot be determined at this stage. This will depend both on the regulatory technique used and on the positions adopted by the various actors.

[98] V. Hatzopoulos 'Health Law and Policy …' above n. 1, p. 168.

Concerning regulatory technique, in policy fields where hard law (the harder you can get: state aids is run on a daily basis and public procurement is regularly monitored by the Commission) has a stronghold, softer means of regulation could seem inappropriate. This view, however, should not overlook two factors. First, that the Commission itself has regularly recourse to soft law in the field of state aids and, recently, also in the field of public procurement (see e.g. the *de minimis* Communication on procurement).[99] Second, that under pressure from technologic development, economic realities and EC law, member states are aware of the fact that inertia is not a policy option in the field of healthcare. Dynamism thus inflicted could be steered towards a converge model through some kind of soft cooperation, 'in particular initiatives aiming at the establishment of guidelines and indicators, the organization of exchange of best practice, and the preparation of the necessary elements for periodic monitoring and evaluation.' The fact that the part of the sentence between inverted comas is directly copied from the Reform Treaty provision dealing with 'Public Health' clearly indicates that this is a road which will be taken.

From the point of view of the actors involved, it has to be observed that the process has been led by private litigators supported by the ECJ. The Commission, on the contrary, has been notably absent. This pattern is likely to continue in the foreseeable future. Even if the Commission decided to assume a more active stance, it could be 'silenced' by member states and their parliaments. Indeed, Article 192(7) of the Treaty on the Functioning of the European Union as modified by the Reform Treaty provides that 'Union action in the field of public health shall fully respect the responsibilities of the member states for the definition of their health policy and for the organisation and delivery of health services and medical care, and the allocation of resources assigned to them'. Moreover, according to Article 12 of the EU Treaty and the Protocols 'on the role of national Parliaments' and 'on the application of the principles of subsidiarity and proportionality' (supposing that the Reform Treaty will come into force) the Commission's initiatives are subject to strong scrutiny.

The use of soft law and soft coordination, combined to the absence of a strong steering from the Commission, make the impact of the EU rules on national healthcare systems very difficult to foresee. This makes the retrospective picturing of their interplay all the more important. This is only a timid first…

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[99] Above n. 40.

Annex

Flow charts of the basic money flows and contractual relationships between entities involved in the public provision of healthcare

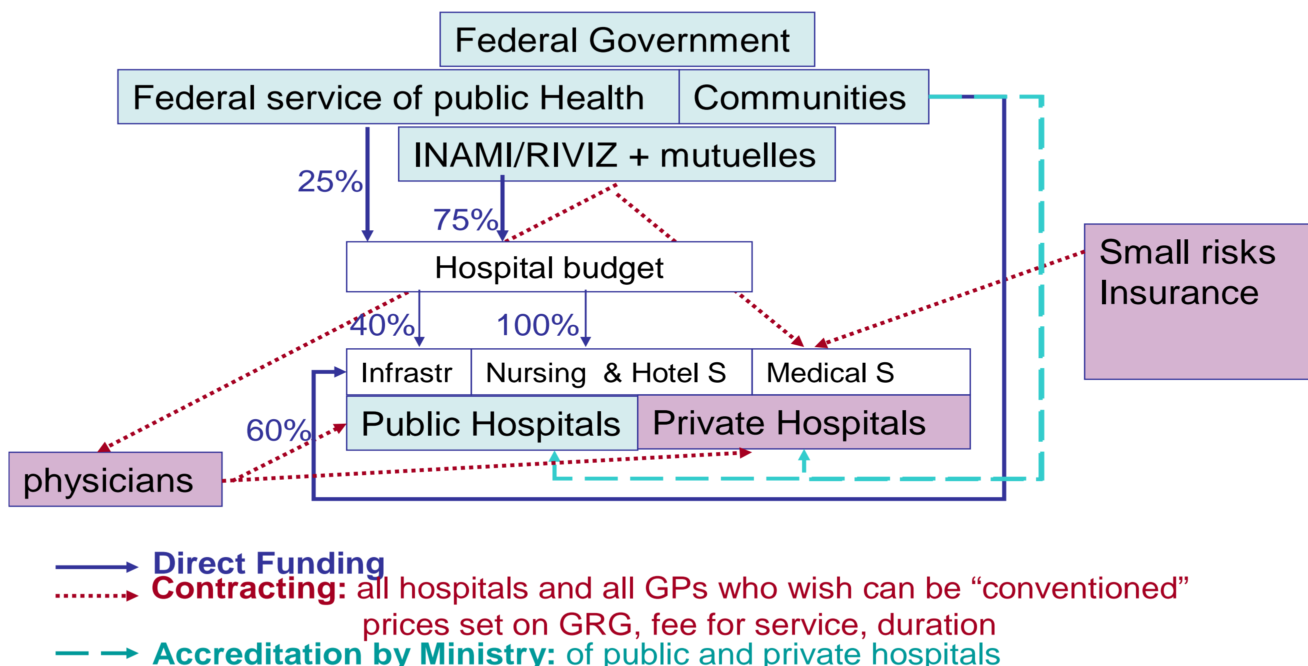
Selected member states

The presentation is limited only on issues which are relevant for the present study and focus on three main questions:

a) what are the main money flows: what is their source, whom do they benefit, under what conditions are they given out, how are sums calculated; and

b) what are the main contractual relationships between the parties involved, how are they entered into and how are their terms determined.

c) what is the nature of the entities involved: purely public bodies or authorities, semi-public, private but depending on the state, private: public bodies are depicted in light blue (light grey) while private entities are depicted in violet (dark grey)



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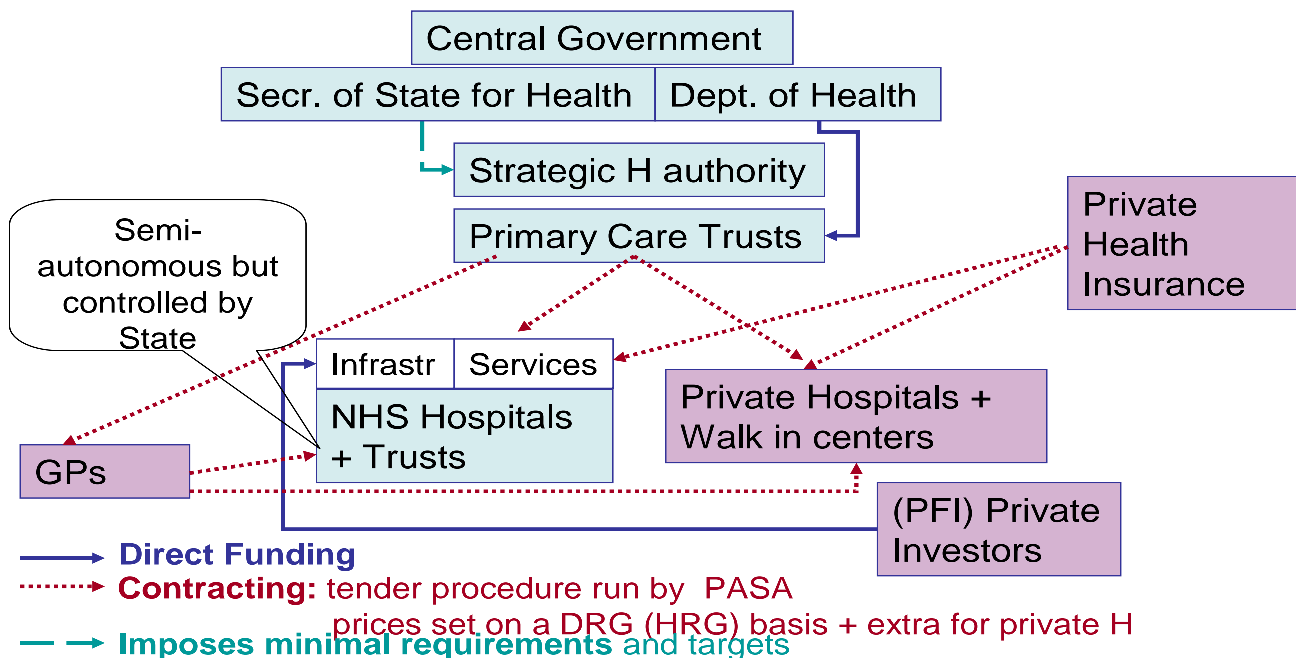

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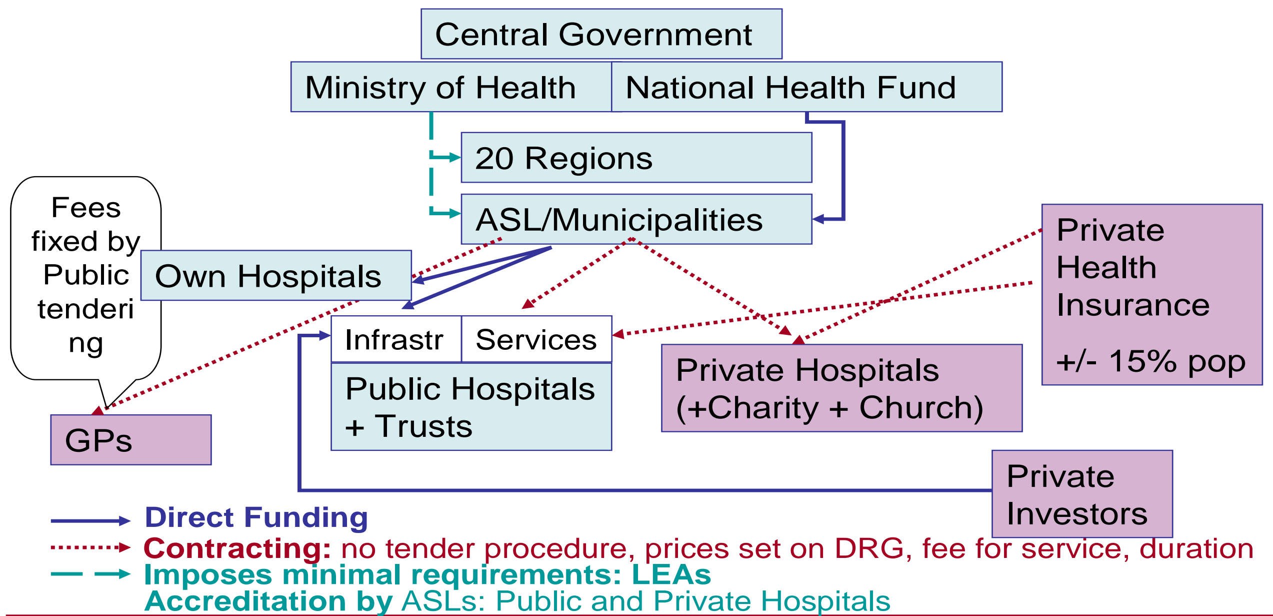

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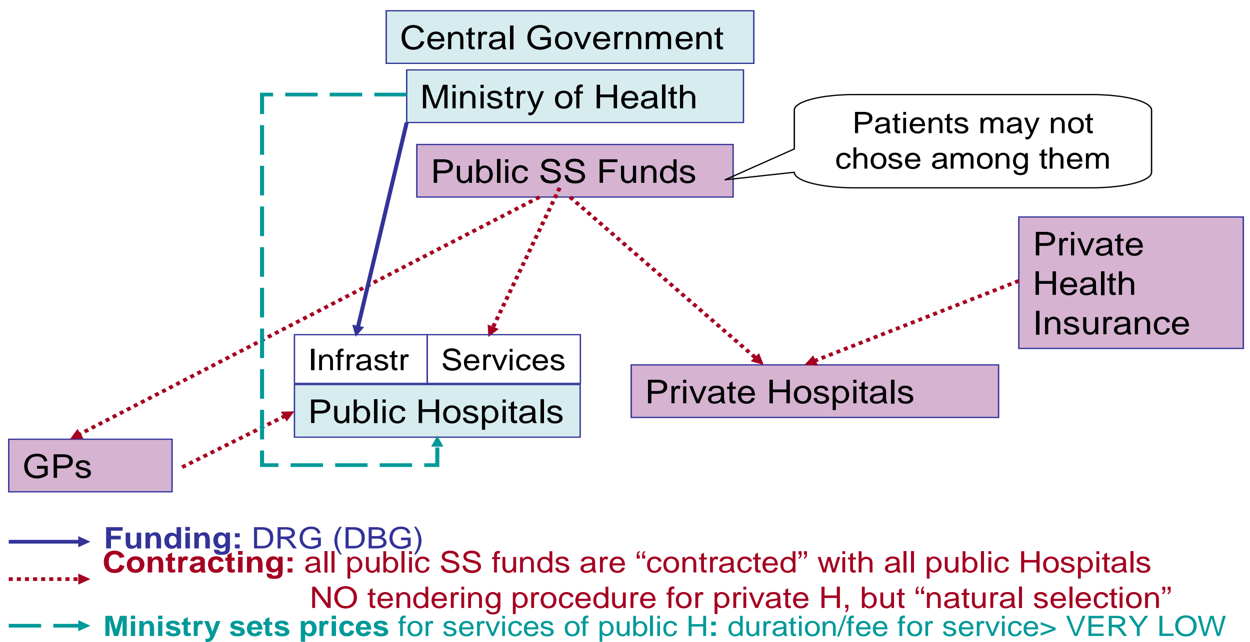

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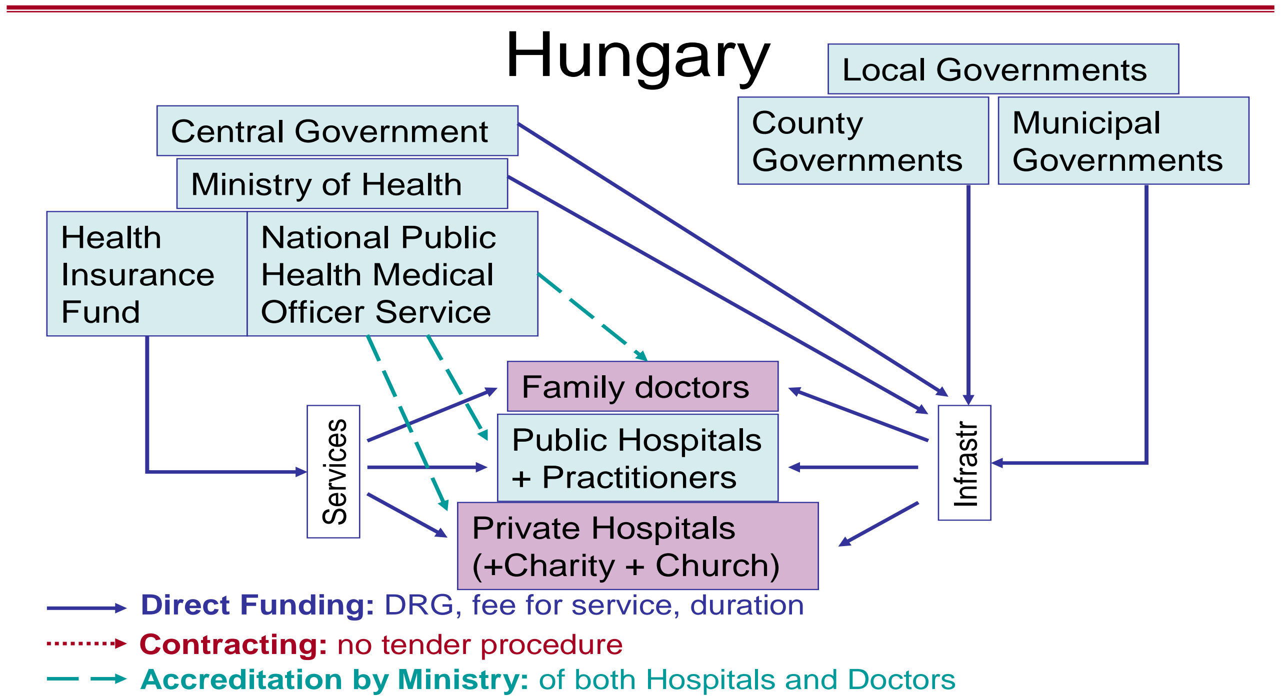

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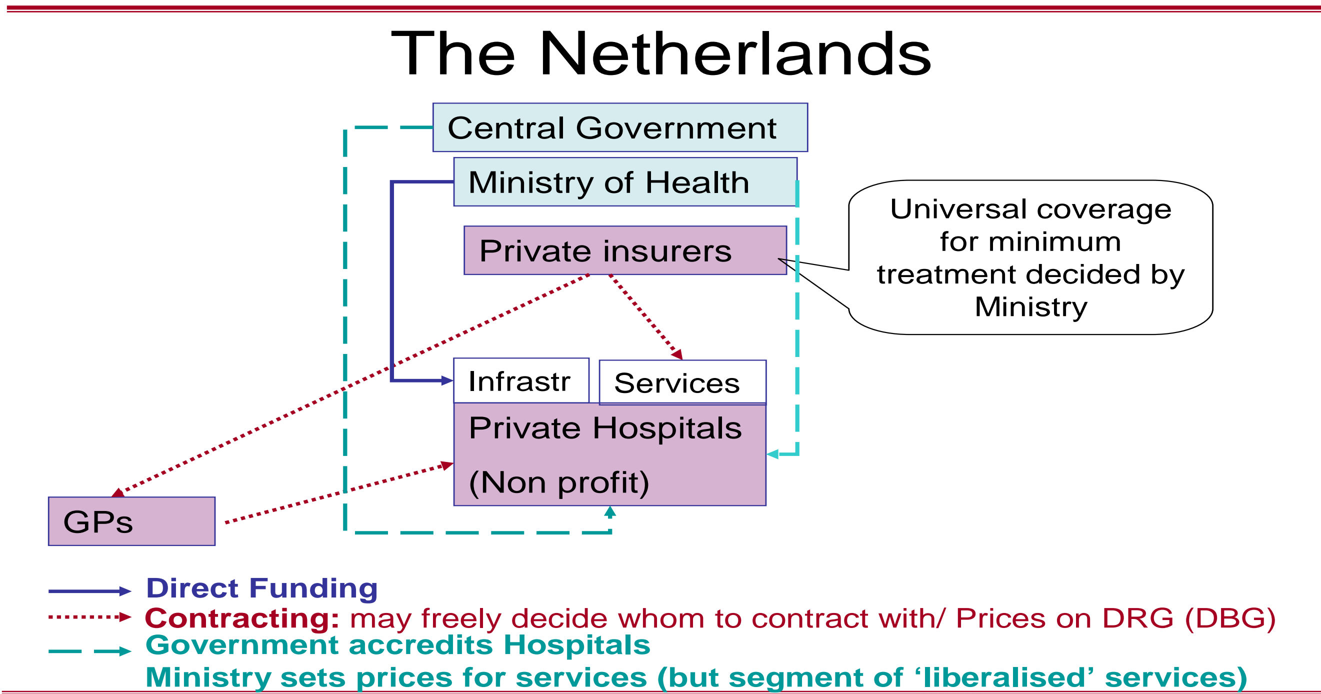

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