

9

Public procurement and state aid in national health care systems

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1. Introduction

The recognition by the European Court of Justice (ECJ) that health care services are services within the meaning of the EC Treaty has very important legal implications, most of which are still to materialize. Free movement of patients, recognized in *Kohll*, *Geraets-Smits and Peerbooms* and their progeny,¹ is just the tip of the iceberg. Much more crucial than accommodating the few thousands of ‘peripatetic’

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¹ Case C-158/96, *Kohll v. Union des Caisses de Maladie* [1998] ECR I-1931; Case C-157/99, *Geraets Smits and 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 judgements of the ECJ in *Vanbraekel* and *Peerbooms*’, *Common Market Law Review* (2002), 683–729; and, more recently, V. Hatzopoulos, ‘Health law and policy, the impact of the EU’, in G. de Búrca (ed.), *EU law and the welfare state: in search of solidarity* (Oxford: Oxford University Press, European University Institute, 2005), pp. 123–60. See also G. Davies, ‘Welfare as a service’, *Legal Issues of European Integration* (2002), 27–40; P. Cabral, ‘The internal market and the right to cross-border medical care’, *European Law Review* (2004), 673–85; and A. P. van der Mei, ‘Cross-border access to health care within the EU: some reflections on *Geraets-Smits and Peerbooms* and *Vanbraekel*’, *Medical Law* (2002), 189–213; and A. P. van der Mei, ‘Cross-border access to medical care: non-hospital care and waiting lists’, *Legal Issues of European Integration* (2006), 167–82; A. Kaczorowska, ‘A review of the creation by the ECJ of the right to effective and speedy medical treatment and its outcomes’, *European Law Journal* (2006), 345–70. For a full account of the relationships between the EU and health law, see T. Hervey and J. McHale, *Health law and the European Union* (Cambridge: Cambridge University Press, 2004).

patients moving from one state to another² is the issue of financing high performing health care systems that have universal coverage.

Financing health care and securing universal coverage traditionally have been tasks attributed to the state. Indeed, even in ‘an era of contractualized governance in the delivery of public services’,³ where the ‘providential state’ gives way to the ‘regulatory state’⁴ and where the containment of public spending is an absolute value, nobody in Europe seriously questions the need for the public funding of health care.⁵ However, once it is established that health care services are ‘services’ within the meaning of the Treaty and that there is a ‘market’ for health care, public money cannot reach this market in an arbitrary way. It has rightly been pointed out that ‘while in the 1990s the debate concerned anti-competitive practices and Article 82 EC ... since the beginning of the current millennium, the main question has shifted to the means of financing public services and to state aid’.⁶ Hence, public funds have either to be disbursed following a competitive tender based on objective and transparent criteria, or to be individually evaluated under the Treaty rules on state aid.

The aim of this chapter is to examine (and to some extent to speculate upon) the ways in which the rules on public procurement and on state aid may affect the organization of public health care systems of Member States. In order to better illustrate the resulting questions, we shall try to base the various findings on the national systems of six Member States.

² See Chapter 12 in this volume.

³ 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?’, *European Law Journal* 90 (2005), 79–109.

⁴ See G. Majone, ‘The rise of the regulatory state in Europe’, *West European Politics* 17 (1994), 77–101; F. McGowan and H. Wallace, ‘Towards a European regulatory state’, *Journal of European Policy* 3 (1996), 560–76.

⁵ Even in the most pro-competitive economies, where provision is increasingly secured through private means, such as in the United Kingdom or the Netherlands, private finance initiatives are perceived as complementary – not an alternative – to public funding; see below.

⁶ L. Idot, ‘Les services d’intérêt général économique et les règles de concurrence’, in J. V. Louis and S. Rodriguez (eds.), *Les services d’intérêt économique général et l’UE* (Belgium: Bruylant, 2006), p. 41, unofficial translation.

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 that have upset the legal scenery (section two), then the law will be applied to the facts, in order to obtain a more precise idea of the ways in which the various health care systems are (or may be) affected by EC rules on state aid and public procurement (section three). Some conclusions will follow (section four).

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 aid are linked in many ways.⁷

A. *Logical links between state aid and public procurement*

First, there is a logical link between state aid and public procurements. When 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 them public contracts. Hence, both sets of rules are designed to prevent public authorities from unduly meddling with markets. The rules on state aid (Articles 87–9 EC) prohibit such money infusions, unless they are specifically ‘declared compatible’ by the Commission, following a notification procedure.⁸ The rules on public procurement, on the other hand, set in Directives 2004/17/EC and 2004/18/EC (the Public Procurement Directives),⁹ require that public contracts be awarded following

⁷ 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?’, *Common Market Law Review* 35 (2002); and, more recently, Bovis, ‘Financing services’, above n.3.

⁸ For a recent and comprehensive account of the Court’s case law concerning state aids, see J.-D. Braun and J. Kuehling, ‘Article 87 and the Community courts: from revolution to evolution’, 45 *Common Market Law Review* (2008), 465–98.

⁹ European Parliament and Council Directive 2004/17/EC coordinating the procurement procedures of entities operating in the water, energy, transport and postal services sectors, OJ 2004 No. L134/1; the ‘General’ Procurement Directive, European Parliament and Council Directive 2004/18/EC on the

stringent requirements of publicity, transparency, mutual recognition and non-discrimination. Adherence to these requirements is overseen by national jurisdictions, which have been awarded extraordinary powers to that effect by the so-called ‘Procedures’ Directives.¹⁰

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 aid is that the recipient of the aid must be an undertaking – and thus money transfers between public bodies or in favour of non-commercial entities are not caught. On the other hand, public procurement rules are deemed to apply to so-called ‘public markets’ (*marchés publics*), ‘where the state and its organs enter in pursuit of the public interest’ and not for profit maximization.¹¹ 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,¹² 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.¹³ Member States have been invited to enumerate in Annex I of

coordination of procedures for the award of public works contracts, public supply contracts and public service contracts, OJ 2004 No. L134/114.

¹⁰ 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 No. L395/33; and Directive 92/13/EEC of 25 February 1992 coordinating the laws, regulations and administrative provisions relating to the application of Community rules on the procurement procedures of entities operating in the water, energy, transport and telecommunications sectors, OJ 1992 No. L76/14. Both Directives have recently been amended by Directive 2007/66/EC of the European Parliament and the Council of 11 December 2007, OJ 2007 No. L335/31.

¹¹ See Bovis, ‘Financing services’, above n.3; C. Bovis, ‘Recent case law relating to public procurement: a beacon for the integration of public markets’, *Common Market Law Review* 39 (2002), 1025–56; and C. Bovis, ‘The regulation of public procurement as a key element of European economic law’, *European Law Journal* 4 (1998), 220–42.

¹² Case C-360/96, *BFI Holding* [1998] ECR I-6821, para. 53.

¹³ See, for example, Case C-44/96, *Mannesmann Anlangebau Austria* [1998] ECR I-73; and Case C-360/96, *Gemeente Arnhem* [1998] ECR I-6821.

Directive 93/37/EC,¹⁴ now replaced by Annex III of Directive 2004/18/EC, national ‘bodies’ that fall into the above category.

However, this enumeration is not exhaustive, and the Court has been called upon on several occasions to interpret the above three conditions. Unsurprisingly, the most controversial condition has been the one related to the distinction between activities in the pursuance of general interest and activities of an industrial or commercial character. Following the judgements of the Court in the *Mannesmann*, *BFI Holding* and, more recently, *Agora and Excelsior* cases,¹⁵ two series of conclusions may be drawn.

First, 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’.¹⁶

Second, in order to ascertain into which of the above categories an activity falls, the Court uses a set of criteria (*faisceau d’indices*), which may be summarized as follows: (a) the absence of considerable competition in providing the same activity; (b) the existence of decisive state control over the said activity;¹⁷ (c) the pursuance of the activity and the satisfaction of the relevant needs in a way that is different from what is offered in the market place; and (d) the absence of financial risk. These are all factors that point towards an absence of industrial and commercial character.¹⁸

These criteria are very similar to the ones used by the Court to ascertain whether an entity is to be viewed as an ‘undertaking’.¹⁹ Therefore,

¹⁴ Council Directive 93/37/EEC concerning the coordination of procedures for the award of public works contracts, OJ 1993 No. L199/54.

¹⁵ Case C-360/96, *BFI Holding*, above n.13; Case C-44/96, *Mannesmann*, above n.14; see also Joined Cases C-223/99 and C-260/99, *Agora and Excelsior* [2001] ECR I-3605.

¹⁶ Joined Cases C-223/99 and C-260/99, *Agora and Excelsior*, *ibid.*, para. 32.

¹⁷ Not the entity providing it; this is a distinct condition directly enumerated in the Directives, see above.

¹⁸ See C. Bovis, *EC public procurement: case law and regulation* (Oxford: Oxford University Press, 2006), Chapter 7; S. Arrowsmith, *The law of public and utilities procurement* (London: Sweet & Maxwell, 2005), Chapter 5.

¹⁹ For these criteria, see below; for more detail on the health care sector, see Hatzopoulos, ‘Health law’, above n.1, pp. 123–60, 149–55. Bovis, ‘Financing services’, above n.3, takes up the same point at p. 84.

it would seem that, to the extent that the two series of criteria are applied consistently, an entity that 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.²⁰ This viewpoint also finds support in the very text of the Utilities Procurement Directive, both in its previous version (Article 8(1), Directive 93/38/EC)²¹ and in its current version (Article 30, Directive 2004/17/EC), 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’.

B. Formal links between state aid and public procurement

This logical link has been turned into a formal one in the Court’s judgement in *Altmark*²² and the Commission’s ‘Altmark package’.²³ In this case, the Court reversed previous case-law, where it followed a ‘state aid’ approach, in favour of a ‘compensation’ approach.²⁴ 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.²⁵ In *Altmark*, the Court held that

²⁰ See also Arrowsmith, *The law of public and utilities procurement*, above n.19, p. 265, taking up this point. The fact that the same entity may qualify as an undertaking for several activities and as a public authority for others (see Chapter 7 in this volume) does not alter the analysis; for any given activity, only one set of rules should be applicable.

²¹ Council Directive 93/38/EC coordinating the procurement procedures of entities operating in the water, energy, transport and telecommunications sectors, OJ 1993 No. L82/39; Article 8(1) of this Directive was interpreted by the Court in Case C-392/93, *R v. HM Treasury ex parte British Telecommunications PLC* [1996] ECR I-1631.

²² Case C-280/00, *Altmark Trans GmbH* [2003] ECR I-7747; for this case, see M. Merola and C. Medina, ‘De l’arrêt Ferring à l’arrêt Altmark: continuité ou revirement dans l’approche du financement des services publics’, *Cahiers de Droit Européen* (2003), 639–94.

²³ For which, see below, in the following paragraphs.

²⁴ See Bovis, ‘Financing services’, above n.3; J. Y. Chérot, ‘Financement des obligations de service public et aides d’état’, *Revue Europe* (2005), 5.

²⁵ 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.

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 a tenderer capable of providing those services at the least cost to the community, the level of compensation needed must be determined on the basis of an analysis of the costs which a typical undertaking, well run and adequately provided with means of transport, would have incurred.²⁶

From the very wording of the fourth condition, it follows that the default setting for the attribution and financing of some public service obligation is through public procurement. Only in the exceptional circumstances where this is not the case should prices be determined according to 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 – for example, 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.²⁷ The only way to benefit from the Court’s judgment in *Altmark* and evade the application of the rules on

²⁶ The excerpt reproduced here summarizes paragraphs 89–93 of the Court’s judgement and is taken from the Commission’s *Altmark* decision, para. 4, for which see the following paragraphs.

²⁷ See, further, for the difficulties of these conditions, *Idot*, ‘Les services’, above n.6.

state aid would be to attribute public service contracts and the related funding to public procurement procedures.²⁸

What is more, the first three conditions of the *Altmark* test are also certain to be 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 two and three.²⁹

The Court's judgement 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/EC³⁰ modifies Directive 80/723/EEC³¹ and requires any undertaking that 'receives public service compensation in any form whatsoever in relation to such service and that carries

²⁸ Since the fourth condition is the hardest 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 for example Bulgarian Commission for the Protection of Competition, Case K3K-175/2006, *Elena Avtotransport*, 2 November 2006, para. 346, reported and briefly commented upon by D. Fessenko, 'The Bulgarian NCA clears state aid in the form of compensation for public transportation services under national state aid rules (*Elena Avtotransport*)', *e-Competitions Law Bulletin* No. 13146 (2007).

²⁹ It may be that the Court in *Altmark* was inspired by European Commission, 'Draft proposal for a European Parliament and Council Regulation 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, 21 February 2002, 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 European Parliament and the Council, and is currently on the verge of being adopted on the basis of a substantially modified draft, see European Commission, 'Communication from the Commission to the European Parliament pursuant to the second subparagraph of Article 251(2) of the EC Treaty concerning the common position adopted by the Council with a view to the adoption of a Regulation of the European Parliament and of the Council on public passenger transport services by rail and by road', COM (2006) 805 final, 12 December 2006.

³⁰ Commission Directive 2005/81/EC of 28 November 2005 amending Directive 80/723/EEC on the transparency of financial relations between Member States and public undertakings as well as on financial transparency within certain undertakings, OJ 2005 No. L312/47.

³¹ Commission Directive 80/723/EEC on the transparency of financial relations between Member States and public undertakings, OJ 1980 No. L195/35.

on other activities' to undertake a separation of accounts of activities for which it receives compensation from its other activities.

- More importantly, Commission Decision 2005/842/EC,³² adopted on the basis of Article 86(3), provides for some kind of 'block exemption' from the state aid rules where the *Altmark* conditions are not met. This 'block exemption'³³ covers three categories of service providers: (a) any service provider of small size (turnover of under €100 million during the last two years) receiving a limited amount of compensation (up to €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 that concerning 'just' compensation. Subsidies falling within the scope of the Decision qualify as state aid (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'³⁴ sets the Commission's position in respect of those subsidies that do not fall either under the *Altmark* judgement (and hence, do not constitute aid) or under the 'Altmark Decision' (and constitute aid that is automatically authorized by the Commission) and need to be notified in order to obtain an individual declaration of compatibility.

The *Altmark* package was further complemented by two texts of (ultra) soft law, in the form of Commission staff working documents, attached to the latest Commission Communication on 'services of

³² Commission Decision 2005/842/EC 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 No. L312/67.

³³ The term 'block exemption' is used here in a generic manner. This Decision based on Article 86(3) EC should not be confused with the five state aid 'block exemptions' adopted by the Commission by virtue of the authorization given to it by Council Regulation 994/98/EC on the application of Articles 92 and 93 of the EC Treaty to certain categories of horizontal aid, OJ 1998 No. L142/1, based on Article 89 EC, a state aid legal basis.

³⁴ Community Framework for state aid in the form of public service compensation, OJ 2005 No. C297/4. 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.

general interest, including social services of general interest'.³⁵ Each of these working documents contains a list of frequently asked questions (FAQs) and answers thereto. The first working document answers questions concerning the application of public procurement rules to social services of general interest,³⁶ while the second (and longest) provides an interpretative tool for the 'Altmark' Decision 2005/842/EC.³⁷ The very fact that the two working documents are attached to the same Commission Communication clearly shows the direct links between public procurement and state aid.³⁸

In light of the above texts, there is no doubt that, despite other approaches previously followed by the Court,³⁹ the so-called 'compensation' approach currently prevails in determining whether public

³⁵ European Commission, 'Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions accompanying the Communication on "a single market for 21st century Europe" – services of general interest, including social services of general interest: a new European commitment', COM (2007) 725 final, 20 November 2007.

³⁶ European Commission, 'Frequently asked questions concerning the application of public procurement rules to social services of general interest', Commission Staff Working Document, SEC (2007) 1514, 20 November 2007.

³⁷ European Commission, 'Frequently asked questions in relation to Commission Decision 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, and of the Community Framework for state aid in the form of public service compensation', Commission Staff Working Document, SEC (2007) 1516, 20 November 2007.

³⁸ While these drafts were being proofread, the *Altmark* orthodoxy received an important blow from the Court of First Instance's (CFI's) judgement in Case T-289/03, *BUPA v. Commission* [2008] ECR II-81. In this judgment, the CFI held that, at least in the field of health, Member States enjoy a wide scope of discretion when defining the scope of services of general interest. Therefore: (a) the content of services of general interest need not be defined in any 'excruciating' detail – hence *Altmark* conditions one and two (clear definition of the subsidized service and transparent calculation of its cost) become more of a theoretical requirement; and (b) conditions three and four (no overcompensation, compared to a normally efficient undertaking) are only controlled by the Commission and Court for manifest error – therefore shifting the burden of proof to the party claiming overcompensation or inefficiencies. It is not clear how this judgment will be received and applied in the future, but this author would be tempted to view a political judgement as being unlikely to reverse the stricter *Altmark* logic.

³⁹ For which, see C. Bovis, 'Financing services', above n.3, who distinguishes: (a) the state aid approach; (b) the compensation approach; and (c) the *quid pro quo* approach.

funds given out for the accomplishment of services of general interest constitute an aid. Under this approach, the rules on public procurement play a pivotal role in two ways: (a) *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 and therefore may receive public funds without being constrained by the rules on state aid); and (b) *internally*, as the main means for the application of Article 86(2) EC in the field of state aid, according to the *Altmark* test.

Thus, 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) Does the undertaking fall into any of the categories contemplated by the 'Altmark' Decision (small size, transport, hospital), in which case the aid is deemed lawful, without notification being necessary? If the answer is negative, then:
- (c) Is the money received compensation for some public service within the meaning of the *Altmark* judgement? 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:
- (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?

C. 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 stressed a great deal by both the Court and the Commission during the last few years.⁴⁰ In fact, the relevant case-law, together with the *Altmark*

⁴⁰ See C. Bovis, 'Developing public procurement regulation: jurisprudence and its influence on law making', *Common Market Law Review* 43 (2006), 461–95.

judgments discussed above, constitute the two main developments of economic law in the Court's case-law. The Court has handed down two series of judgements 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 *Commission v. France, Nord Pas de Calais*,⁴¹ 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*,⁴² 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 that involves public funding and is not covered by the Procurement Directives). *Coname*⁴³ 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*,⁴⁴ 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*'.⁴⁵ The same was confirmed some days later in *Contse*,⁴⁶ which concerned 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

⁴¹ Case C-225/98, *Commission v. France* [2000] ECR I-7445.

⁴² Case C-324/98, *Telaustria* [2000] ECR I-745.

⁴³ Case C-231/03, *Coname* [2005] ECR I-7287.

⁴⁴ Case C-458/03, *Parking Brixen* [2005] ECR I-8612.

⁴⁵ *Ibid.*, para. 48 (emphasis added).

⁴⁶ Case 234/03, *Contse* [2005] ECR I-9315.

minimis Communication’).⁴⁷ This Communication covers: (a) contracts below the thresholds for the application of the Procurement Directives; and (b) contracts that are covered by the Directives but are listed in Annex IIB of the General Procurement Directive and in Annex XVIIIB 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 was initiated by the Commission’s White Paper of 2004, followed by a Communication of November 2005;⁴⁸ the outcome of the process was the 2008 Interpretative Commission Communication.⁴⁹ The *de minimis* Communication basically explains the way in which the principles set out in 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 to 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 points. 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) that are included in Annex IIB (and XVIIIB of the Utilities Directive): the Procurement Directives themselves set minimal requirements concerning the technical specifications

⁴⁷ European Commission, ‘Interpretative Communication on the Community law applicable to contract awards not or not fully subject to the provisions of the public procurement directives’, OJ 2006 No. C179/2.

⁴⁸ European Commission, ‘Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on public-private partnerships and community law on public procurement and concessions’, COM (2005) 569 final, 15 November 2005.

⁴⁹ European Commission, ‘Interpretative Communication on the application of Community law on public procurement and concessions to institutionalized public-private partnerships (IPPP)’, C (2007) 6661, 5 February 2008. See http://ec.europa.eu/internal_market/publicprocurement/ppp_En.htm.

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 point leads to the second: since the legislator specifically decided to treat services included in Annex IIB (and XVIIIB 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 judgement in *Placanica*, a case concerning bet collection in Italy.⁵⁰ 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 a 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'.⁵¹ This reflects an idea that is being implemented in the regulated industries (telecommunications, energy, etc.) and that had been put forward by the Commission (but never taken up) on a more general scale, concerning access to essential facilities:⁵² whenever some scarce resource is to be distributed between competitors, the way to do it is through public tendering procedures.

Hence, not only do the basic procurement principles (i.e., non-discrimination and equal treatment, transparency, proportionality

⁵⁰ Joined Cases C-338/04, C-359/04 and C-360/04, *Placanica* [2007] ECR I-01891.

⁵¹ *Ibid.*, para. 63 (emphasis added).

⁵² Organisation for Economic Co-operation and Development, 'The essential facilities concept', OECD/GD(96)113 (1996), Contribution of the European Commission, pp. 93–108, at 102, [www.oilis.oecd.org/olis/1996doc.nsf/LinkTo/OCDE-GD\(96\)113](http://www.oilis.oecd.org/olis/1996doc.nsf/LinkTo/OCDE-GD(96)113).

and mutual recognition) apply to all tenders involving public money,⁵³ 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. Hence, if a *limited* number of hospitals were to be accredited into a national health care system or a *limited* number of insurance funds admitted to participate in a national insurance system, they should be chosen according to the above principles.⁵⁴

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 key components of the regulatory framework of the internal market.

3. Applying the EC rules to national health care

Against this background, the question arises: if, how and to what extent do the rules – or, indeed, the principles – on public procurement and those on state aid affect – or should affect – the provision of health care in the Member States?⁵⁵

The organization of health care in all Member States constitutes an expression of social solidarity.⁵⁶ As such, it shares some basic characteristics: it is intended to have universal coverage, it is publicly funded

⁵³ It is interesting to note in this respect that, following the judgement of the Court in Case C-507/03 *Commission v. Ireland*, An Post [2007] ECR I-9777 and Case C-119/06, *Commission v. Italy, Ambulance services* [2007] ECR I-168 (for which see below), it became clear that while the Directive rules apply to all awards above the thresholds, the general procurement principles require that the affectation of the internal market be positively established.

⁵⁴ The situation is different if an indeterminate number of entities (hospitals, funds, etc.) that fulfil specific requirements fixed in advance are admitted into the system; a different question still arises when Member States decide to run their health care/insurance systems relying exclusively on purely public bodies.

⁵⁵ For the first (and latest) official position on this issue see European Commission, 'Communication from the Commission', above n.35. This Communication comes with two 'working documents': European Commission, 'Frequently asked questions', above n.36; and European Commission, 'Frequently asked questions', above n.37.

⁵⁶ Newdick puts forward the idea that social solidarity thus organized is placed in danger by the negative integration measures pursued by the ECJ. See C. Newdick, 'Citizenship, free movement and health care: cementing individual rights by corroding social solidarity', *Common Market Law Review* 43 (2006),

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, health care 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 health care in Member States. For this reason, it will be useful to ground the present inquiry on specific Member State case-studies and offer illustrations based upon these.⁵⁷

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,⁵⁸ in the analysis that follows we shall examine each individual criterion rather than the two sets of rules separately.

A. *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*.

There is no doubt that providing health care 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, that 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 health care:

- (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

1645–68; see also R. Houtepen and R. ter Meulen, ‘New types of solidarity in the European welfare state’, *Health Care Analysis* 8 (2000), 329–40.

⁵⁷ 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.

⁵⁸ See above section 2 subsections A and B of the present C.

- modification, pain treatment and 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 to have access to the system; (v) waiting time to receive any given treatment, etc.; and
 - (c) the quality of nonmedical services, such as accommodation, catering, cleaning, etc.

In most Member States, the level of health care that should be provided is described in one or more legislative acts (see, for example, the 1987 Hospital Act in Belgium, the 1977 NHS Act in the United Kingdom, etc.) or some other regulatory act (see, for example, the 2001 Agreement between the Government, the Regions and the Provinces of Trento and Bolzano for the Application of Legislative Decree 502/1992 in Italy). In some states, a general provision securing a high level of health care to the population is also to be found in the Constitution (see, for example, Article 70(D) of the Hungarian Constitution and, in less compelling formulations, Article 22 of the Dutch Constitution, Article 23 of the Italian Constitution, Article 23(2) of the Belgian Constitution or Article 21(3) of the Greek Constitution).⁵⁹

These norms, however, even when they go beyond mere principles, very rarely provide a detailed description of the above variables and, hence, fail to define the precise scope of general interest in health care. Next to these general rules, very specific and complex rules are

⁵⁹ 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 natural environment.' The Constitutional Court of this country has decided that this is not an absolute and static right, but 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 and T. Shapiro, 'Constitutional rights and the reform of social entitlements', in L. Bokros and J.-J. Dethier (eds.), *Public finance reform during the transition. The experience of Hungary* (Washington, DC: World Bank, 1988).

to be found concerning the calculation of various treatment units, the funding of the various parts of hospital budgets, etc.⁶⁰ Usually, however, these technical rules relate to the cost of specific activities and treatments and do not represent the entire cost of services of general interest in health care.

Therefore, it would seem that the application of EC law would require the introduction, in the field of health care, of the concept of 'service of general interest' or 'public service' and a precise definition of its content. This would be necessary both 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 that is 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 formally 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 No. 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.⁶¹

Second, the *Altmark* ruling entails a logical shift: while the national logic is one of defining the scope of a health care *system*, the EC logic is to define a *set of* health care *services* of general interest. This, in turn, may entail re-assessing some of the assumptions concerning

⁶⁰ For which see below.

⁶¹ See the explanatory memorandum of the proposal in the Belgian Chamber of Representatives, www.dekamer.be/FLWB/pdf/51/2760/51K2760001.pdf.

the provision of health care. 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.⁶²

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’.⁶³ This view finds support in the case-law of the Court. In this respect, it may be useful to compare the judgments of the Court concerning ambulance services. In the Austrian *Tögel* case,⁶⁴ the Court reasoned that any award of ambulance transport contracts should be made according to the ‘Services’ Directive 92/50/EEC, provided that this text had become binding at the relevant date (which was not the case for Austria). Taking this point further, in *Commission v. Italy, Ambulance Services*,⁶⁵ the Court made clear that the obligation to abide by the public procurement rules (or, depending on the circumstances, principles) remains even if the intention of the authority is to award the contract to a non-profit organization (such as the Red Cross) using personnel working on a volunteer basis.⁶⁶

In the German *Glöckner* case,⁶⁷ on the other hand, the Court admitted that ambulance contracts could be awarded on the basis of a prior authorization, 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,

⁶² In some states, such a distinction is already made – for example, in Belgium, both hospitals and practitioners may charge supplements to patients staying in single or double rooms; for occupants of double rooms, there is a cap on the supplements charged, while for those living in single rooms there is no cap, either for ‘hotel’ or for medical services.

⁶³ See Commission Decision 2005/842/EC, above n.32, Recital 7; and Community Framework, above n.34, Recital 9.

⁶⁴ Case C-76/97, *Tögel* [1998] ECR-5357.

⁶⁵ Case C-119/06, *Commission v. Italy*, above n.53.

⁶⁶ In this specific case, however, the Court dismissed the Commission’s action, because the Commission had failed to prove: (a) that the total amount of the contract was above the thresholds for Council Directive 92/50 to be applicable; and (b) that the contract did present some trans-border interest for the general Treaty rules to become applicable.

⁶⁷ Case C-475/99, *Glöckner* [2001] ECR I-8089.

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. The same non-interventionist stance was followed by the Court more recently in *Commission v. Ireland, Ambulance Services*.⁶⁸ In this case, the Court found no contractual relationship – and hence no award – to exist between the Health Authority and the Dublin City Council, which provided ambulance services, each one of them being empowered by law to provide emergency ambulance services. Finally, it should be remembered that, in the *Commission v. Italy, Ambulance Services* cases discussed above,⁶⁹ the Court, despite its broad statements in favour of the applicability of the procurement principles, allowed the Member State to pursue its system of contract award.

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 indirect nature. Therefore, in *Geraets-Smits and Peerbooms*,⁷⁰ the Court held 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 it is obtained in another Member State. Similarly, in *Müller-Fauré*,⁷¹ 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:⁷² 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 health care – health care itself may be purchased at any time, at the right price. In such a scenario, only the sickness insurance funds would be performing some task of general economic interest. However, in view of the preceding paragraphs and

⁶⁸ Case C-532/03, *Commission v. Ireland*, above n.53.

⁶⁹ Case C-119/06, *Commission v. Italy*, above n.54.

⁷⁰ Case C-157/99, *Geraets Smits and Peerbooms*, above n.2.

⁷¹ Case C-385/99, *Müller-Fauré* [2003] ECR I-4509.

⁷² See, for example, G. Chavrier, 'Etablissement public de santé, logique économique et droit de la concurrence', *Revue du Droit de la Sécurité Sociale* (2006), 274–87.

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.

B. How is it financed?

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

Distinguishing capital costs from exploitation costs

In most Member States (all those studied in this chapter), there is a more or less clear distinction between, on the one hand, capital investment, infrastructure, etc., and, on the other hand, exploitation costs, directly linked to the number of units produced (patients/treatments administered).⁷³ Two points should be made in this respect.

First, this dissociation, spontaneously made by Member States, corresponds to the model chosen by the EC legislature for the development of another field where infrastructure occupies a very important role: rail transport.⁷⁴ 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.⁷⁵ Hence, it remains to be ascertained, at a state-by-state level, how this distinction works for health care. Furthermore, 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

⁷³ In the Netherlands, however, this has changed as of 2008; the system whereby capital costs were not included in the total sum hospitals could claim from the contracted health insurers has been replaced by one whereby part of capital costs are negotiable (between hospitals and insurers) and included in DRGs.

⁷⁴ See Article 6, Council Directive 91/440/EEC for the development of community rail, OJ 1991 No. L237/25.

⁷⁵ See Article 6(2), European Parliament and Council Directive 2001/12/EC modifying Directive 91/440, OJ 2001 No. L75/1.

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% is funded by the Communities. When Belgian hospitals conclude contracts with Dutch health insurers, they charge the same tariffs to them as they do to the Belgian health insurance system. This means that the investment cost for hospitals is only charged at 40%. Some Dutch hospitals do perceive this to be a distortion of competition and a Dutch organization of hospitals stated that they consider this to be non-permissible state aid in favour of Belgian hospitals.⁷⁶ It is difficult, however, to see how such a distortion could be remedied. The 40:60 funding ratio, 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 aid (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, infrastructure and other fixed costs traditionally have been financed directly by the public purse, but, in recent years, some states have tried to attract private investment. The Private Funding Initiative (PFI) in the United Kingdom has set the pace, and other countries have followed suit. The emergence of new contractual forms, such as public–private partnerships (PPPs) and concessions offer further means of bringing in private funds. These will not be examined in the present chapter, but one remark should, nonetheless, be made: the choice of private investors who will participate in contributing capital to public hospitals (like in other public infrastructure) may only be made following the ‘public procurement principles’.⁷⁷

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 costs (see above) 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

⁷⁶ I. Glinos, N. Boffin and R. Baeten, *Cross-border care in Belgian hospitals: an analysis of Belgian, Dutch and English stakeholder perspectives* (Brussels: Observatoire social européen, 2005), p. 66.

⁷⁷ See above, section 2, subsections B and C.

of expenses has been reviewed in most Member States during the last few years. In order to create incentives to contain cost and rationalize treatments, three main directions have been followed: (a) advance payments through prospective budgets based on average costs of hospitals in the same category; (b) calculation of the average costs on the basis of diagnosis-related group (DRG) or equivalent measuring unit,⁷⁸ only occasionally completed or adjusted by the application of fee-for-service or length-of-stay criteria; and (c) the possibility of efficient hospitals keeping any surplus. Not only do these measures force the hospitals to pursue a sounder management of financial resources, 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 of the Member States examined herein, 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 system, where fees are fixed under the auspices of the public fund (National Institute for Health and Disability Insurance (NIHDI)) and may or may not be adhered to by each individual physician.⁷⁹ There are three reasons for this: first, because price fixing by public authorities and/or professional

⁷⁸ Diagnoses Related Groups (DRGs) or equivalent measuring units (Diagnose Behandelings Combinaties (DBC) in the Netherlands, Healthcare Resource Groups (HRGs) in England). DRGs are predefined pairs, whereby each specific medical condition is matched up with a determined treatment and/or length of stay.

⁷⁹ The Court is not particularly keen on price fixing by professional associations and other bodies. See recently Joined Cases C-94/04 and C-202/04, *Cipolla e.a.* [2006] ECR I-11421. See also, at the national level, a settlement reached before the Irish Competition Authority on 25 May 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 upon by O. Lynskey, 'The Irish Competition Authority settles price-fixing proceedings in the health insurance sector', *e-Competitions Law Bulletin* No. 14004 (2007); and by C. Hatton and S. A. Kauranen, 'The Irish Competition Authority settles an alleged price-fixing dispute in the health

organizations may fall 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 the market price in any given geographic area; and, 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 the price public hospitals should charge practitioners for use of hospital infrastructure in order to offer ‘fee-for-service’ health care services outside the health system. In this respect, a recent judgment of the French Council of State clearly illustrates the strain public health systems are going through:⁸⁰ in the face of well-established legislation and jurisprudence that allowed only for the payment of a flat ‘occupancy fee’ for 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 existing in other Member States: in England, practitioners retain a portion of the revenues realized privately 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 intermediaries involved. The more diverse the routes for public monies 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) receive money for their services 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 health insurance fund’s money

sector relating to medical examination reports to life insurance companies’, *e-Competitions Law Bulletin* No. 13967 (2007).

⁸⁰ Case No. 293229, *Syndicat National de Défense de l’Exercice Libéral de la Médecine à l’Hôpital*, Conseil d’Etat, 16 July 2007, www.legifrance.gouv.fr/affichJuriAdmin.do?oldAction=rechJuriAdmin&idTexte=CETATEXT000018006881&fastReqlId=620987082&fastPos=1; for this case, see, briefly, B. du Marais and A. Sakon, ‘According to the French State Council, the tariff that public hospitals levy on private activities of medical doctors employed as civil servants can partly be related to a market price’, *Concurrences* (2007), 148–50.

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 aid law more likely.

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 from notification and automatically legal, irrespective of the amount. Aid awarded to hospitals, however, needs to be strictly measured on the accomplishment of a 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 some system of monitoring should be set up as a consequence of the *Altmark* requirements.⁸¹ 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 needs to 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 management⁸² 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 materialize in the hospital sector.

⁸¹ It would seem that Commission Decision 2005/842/EC, above n.32, does require some monitoring, especially to oversee overcompensation; see Article 4(d).

⁸² Such a system was introduced, for example, in Belgium in 2001: the overall available budget is divided into 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 and 2009 follows a similar pattern: the Department of Health (DoH) sets national tariffs for Healthcare Resource

The above considerations apply to monies given to hospitals directly by the state budget (e.g., in England),⁸³ or by public insurance funds or funds where membership is compulsory (e.g., in Italy, Hungary, Belgium and Greece).⁸⁴ It is unclear whether the same principles apply to a system like the Dutch one, 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' monies 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 of some fund is compulsory may lead to a positive answer.⁸⁵ If the former solution were retained and no 'public' monies were involved, then payments from health funds to hospitals would not qualify as state aid at all and could only be scrutinized 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.

C. *Who is a contracting entity and 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

Groups (HRGs), 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.

⁸³ The Department of Health (DoH) gives tax money to the primary care trusts (PCTs), which in turn contract with public and private hospitals and general practitioners (GPs).

⁸⁴ See, for an example where a state aid was given by the Belgian pension fund ONSS (which is the NIHDI 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, *Maribel* [1999] ECR I-3671.

⁸⁵ It should be noted that in another context, in Case C-75/97, *Maribel, ibid.*, para. 23, as well as in Case C-200/97, *Ecotrade* [1998] ECR I-7907, para. 34, the Court has held that 'measures which, in 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'.

broad as ‘the exercise of an economic activity’.⁸⁶ On the one hand, a contracting entity is one that ‘does not pursue an activity of an economic or commercial nature’.⁸⁷ What is more, one of the fundamental principles of a market economy is that operators may contract with whomever they wish:⁸⁸ any given entity may not be subject simultaneously to free competition and to the restrictive and time-consuming rules of public procurement.⁸⁹ However, this is not necessarily true in a hybrid economic sector, such as the provision of health care. Possibly more controversial than the technical issues above is the more general question of whether health care provision should be subject to the procurement rules at all. In this respect, some of the arguments put forward against the general application of public procurement rules to the core of health care provision include: (a) the lack of flexibility of the procurement rules, especially in respect of the role of non-profit social organizations; (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) delays.⁹⁰ 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

⁸⁶ See also Chapters 7 and 8 in this volume. For a more thorough analysis of the concept of ‘economic activity’, see O. Odudu, *The boundaries of EC competition law* (Oxford: Oxford University Press, 2006), pp. 26–45.

⁸⁷ See Arrowsmith, *The law of public and utilities procurement*, above n.18; and Bovis, *EC public procurement*, above n.18.

⁸⁸ This ‘freedom to deal’ is known in competition law as the ‘Colgate doctrine’ from the US Supreme Court’s judgment in *United States v. Colgate & Co.*, 250 US 300 (1919).

⁸⁹ See above section 2, subsections B and C.

⁹⁰ See, for example, European Commission, ‘Social services of general interest: feedback report to the 2006 questionnaire of the Social Protection Committee’, pp. 10–2, http://ec.europa.eu/employment_social/social_protection/docs/feedback_report_en.pdf. See also (on an earlier set of replies from the Member States) M. Maucher, ‘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’, Observatory for the Development of Social Services in Europe, 16 September 2005, www.soziale-dienste-in-europa.de/Anlage25573/auswertung-antworten-ms-mitteilung-sgdai-ed.pdf.

accompanying documents.⁹¹ In these texts, the Commission confirms its attachment to the application of the public procurement rules and principles in the area of health care.

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.⁹²

- Belgium considers three hospital centres owned by the central government to be contracting authorities.⁹³ 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. Until the last revision of the Annex, in effect from January 1, 2009, the NIHDI was also included, but has been taken off the list ever since. Several other funds, mostly pension ones, are also included in the list.
- Italy enumerates indistinctively all bodies administering compulsory social security and welfare schemes and a general category of ‘organizations providing services in the public 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); also in Annex XII (Central government authorities) two public hospitals are expressly enumerated.
- The Netherlands lists the university hospitals, within the meaning of the Law on Higher Education and Scientific Research and

⁹¹ See European Commission, ‘Communication from the Commission’, above n.35; and the accompanying ‘working document’, European Commission, ‘Frequently asked questions’, above n.36.

⁹² This annex has been modified for the last time by Commission Decision 2008/963/EC of 9 December 2008 [2008] OJ L 349/1, with effect as of 1 January, 2009.

⁹³ The majority of hospitals in Belgium are private hospitals (151 out of 215, equal to 70%, in 2005). Most private hospitals are owned by

several bodies involved in the management of hospital facilities, accreditation of health providers, etc.

- 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 centralize and carry out procurement on behalf of all NHS entities.
- Hungary gives general definitions broadly in the same sense as Greece.

From the above list, it becomes clear that, even in public procurement, an area where substantial harmonization has been taking place for over twenty years 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 on the role the various entities play in their respective health care systems.

Undertakings everywhere?

There is no doubt that self-employed physicians, even when they are contracted in a national health care scheme or in a hospital, are undertakings.⁹⁴ In contrast, doctors who are public employees (for instance, as is 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

religious charitable orders, while the remainder are 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.

⁹⁴ Joined Cases C-180/98 to 184/98, *Pavlov a.o.* [2000] ECR I-6451.

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 the commercial freedom of these entities may be jeopardized. Hence, for example, regulatory measures in Germany and (prior to 2006)⁹⁵ in the Netherlands imposed on private insurers:

[T]he 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.⁹⁶

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 called 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,⁹⁷ it follows that elements that would point to a

⁹⁵ For details on the recent modification of the Dutch health insurance system, see the contributions by G. J. Hamilton, 'A new private universal Dutch health insurance in the Netherlands'; E. Steyger, 'The proposed Dutch health insurance system in the light of European Law'; and J. van der Gronden, 'Is a Member State entitled to introduce regulated competition into the health care sector under EC law? Reaction to the contribution of Prof. E. Steyger', in A. den Exter (ed.), *Competitive social health insurance yearbook 2004* (Rotterdam: Erasmus University Press, 2005).

⁹⁶ For this excerpt and for the critique that follows, see S. Thomson and E. Mossialos 'Regulating private health insurance in the EU: the implications of single market legislation and competition policy', *European Integration* 29 (2007), 89–107, at 93–4.

⁹⁷ See Case C-238/94, *FFSA* [1995] ECR I-4013; Case C-70/905 *Sodemare* [1997] ECR I-3395; Case C-67/96, *Albany International v. Stichting Bedrijfspensioenfondstextielindustrie* [1999] ECR I-5751; Joined 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 L. Idot, 'Droit social et droit de la concurrence: confrontation ou cohabitation

non-market entity include:⁹⁸ (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; (h) cross-subsidization between different schemes; and (i) the non-existence of competitive schemes offered by private operators.⁹⁹

In this respect, the judgment in *FENIN* should be singled out,¹⁰⁰ not least because the Court, in appeal proceedings from the Court of First Instance, confirmed that an entity that 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.¹⁰¹ This, however, has not prevented the Polish Office for Competition and Consumer Protection, in a decision of March 2007,¹⁰² from censuring the National Health Fund, whose task is to ensure health services to insured persons (a traditional public authority task), for abusing its dominant position (!) by fixing below-cost contracting prices for dentists.

(à propos de quelques développements récents), *Europe* (1999), 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-205/03 P, *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.

⁹⁸ Note that these are broadly the same considerations – but from the opposite perspective – as the ones used to identify contracting entities, see above n.19 and the relevant text.

⁹⁹ For a more detailed analysis of those criteria, see Hatzopoulos, ‘Health law and policy’, above n.1, pp. 123–60. For a critical view of the Court’s meddling with social funds, see F. Kessler, ‘Droit de la concurrence et régimes de protection sociale: un bilan provisoire’, in R. Kovar and D. Simon (eds.), *Service public et Communauté Européenne: entre l’intérêt général et le marché*, Vol. I (Paris: La documentation française, 1998), pp. 421 and 430, where there is reference to other critical commentators.

¹⁰⁰ Case C-205/03 P, *FENIN*, above n.97.

¹⁰¹ See M. Krajewski and M. Farley, ‘Non-economic activities in upstream markets and the scope of competition law after *FENIN*’, *European Law Review* 32 (2007), 111–24.

¹⁰² Decision No. DOK 28/2007 of 7 March 2007 concerning the practices of the National Health Fund, reported and commented upon by J. Farrugia and by M. Tomaszewska, ‘The Polish Office for Competition and Consumer

At the other end of the spectrum, on the basis of the *FENIN* reasoning, it would seem that public hospitals securing adequate treatment to individual patients, typically free of charge, do not qualify as undertakings. This logic, however, is being called into question by at least two developments. First, in its ‘Altmark’ Decision, the Commission admits that monies given to hospitals (irrespective of ownership) for fulfilling their public service obligations qualify as aid, albeit justified aid. 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, blocked a merger between two public hospitals; hence, it considered them to be undertakings subject to merger control.¹⁰³ Although this decision of the German competition authority is in line with its previous law concerning utilities,¹⁰⁴ one may object that the utilities sector has been heavily regulated for more than twenty years, both at the level of procurement and at the level of deregulation/re-regulation, and that comparing health care with the utilities sector, at this stage of Community law, is materially inappropriate and legally inconclusive. The trend of holding public hospitals as subject to competition (and therefore to competition rules) has been confirmed in the 2007 *Amphia* judgment of the Dutch Supreme Court, whereby it held that public hospitals are subject to enough competition so as not to qualify as ‘contracting authorities’.¹⁰⁵

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; and (d) a relatively developed side activity of a commercial nature, etc., are likely to

Protection holds that the National Health Fund has imposed its dominant position by imposing low purchase prices of health services (Narodowy Fundusz Zdrowia), *e-Competitions Law Bulletin* No. 13674 (2007).

¹⁰³ Decision B10–123/04, *Rhön-Klinikum AG, Landkreis Rhön-Grabfeld*, Bundeskartellamt, 23 March 2005, reported and commented upon by H. Bergmann and F. Röhling, ‘The German Federal Cartel Office vetoes a merger of two public hospitals (*Greifswald University Hospital/ Wolgast Hospital*)’, *e-Competitions Law Bulletin* No. 12733 (2006).

¹⁰⁴ According to the above commentary.

¹⁰⁵ For this case see V. Hatzopoulos & H. Stergiou ‘Public procurement law and health care: From theory to practice’ in Can de Gronden, J., Krajewski, M., Neergaard, U., & Szyzszak, E., *Health Care and EU Law* (The Hague: Asser Press, forthcoming).

make a public hospital qualify as an undertaking.¹⁰⁶ Hence, hospitals having the form of a trust, for example, in England and in Italy, are likely to qualify as undertakings.

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 health care qualify as contracting entities; and (b) entities that some years ago were thought of as completely evading the market rules are increasingly being treated as undertakings at the EU and at the national levels. What is more, these imprecise categories often overlap. We saw that many Member States (such as Belgium, Greece and Italy) have included in Annex III of the Procurement Directive health care 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, for example, in England, through PASA, and in Greece and Hungary).¹⁰⁷ 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 ones, would qualify as undertakings. This is not a satisfying situation, for the reasons explained above in section two, subsections B and C. As will be explained in section three, subsection D, below, for an entity involved in health care, 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 ‘decentralization’ of the application of EC competition law introduced by Regulation 1/2003/EC,¹⁰⁸ as it may lead to very divergent solutions, especially concerning borderline hospitals. In this respect, Decision 2005/842/

¹⁰⁶ 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 EC Treaty competition rules.

¹⁰⁷ Greece has had an infringement procedure initiated against it by the Commission for the technical specifications used in several tendering documents for the supply of medical devices, see Case C-489/06, *Commission v. Greece* (not yet reported).

¹⁰⁸ Council Regulation 1/2003/EC on the implementation of the rules on competition laid down in Articles 81 and 82 of the EC Treaty OJ 2003 No. L1/1.

EC (the ‘Altmark’ Decision) is a positive step, since it clears hospitals, irrespective of their qualification as undertakings, from the application of the state aid 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 82¹⁰⁹ 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 health care field – that is, to require Member States to provide a complete list of all the entities that are considered to be contracting entities (thus evading their being qualified as undertakings) and to implement 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.

D. What kind of award procedures should be followed?

When an entity in the field of health care qualifies as a ‘contracting authority’ 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 (health care, included in Annex III of the Procurement Directive). Four cases may be distinguished.

No contractual relationship

In some health care systems, the public authorities responsible for delivering care establish and run their own treatment facilities, in the form of treatment centres, small hospitals or clinics. Such is the case, for example, of the ASLs in Italy or the PCTs in England, and 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.¹¹⁰ In-house provision applies to any service offered between bodies with no separate legal personality. In the

¹⁰⁹ For further discussion of Articles 81 and 82 EC, see Chapters 7 and 8 in this volume.

¹¹⁰ See, in general, Arrowsmith, *The law of public and utilities procurement*, above n.18, paras. 6.196–6.193. See also M. Giorello, ‘Gestions *in house*,

presence of distinct legal entities, in-house provision only exists where two conditions are fulfilled, in a cumulative manner:¹¹¹ (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 judgement, in *Teckal*,¹¹² 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 that controls the remaining 99.98%, unless such an authority holds special privileges by virtue of the company’s constitution. This may discourage public hospitals from seeking private investors or, conversely, investors from giving money to entities in which the public authorities have privileges.¹¹³ 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 health care systems like the Hungarian and the Greek systems, where all public hospitals cooperate, by law, with all public funds. In all these cases, the qualification of a body as a contracting authority has legal consequences only when the entities concerned purchase extra capacity, outside their own ‘production’.

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

entreprises publiques et marchés publics: la CJCE au croisement des chemins du marché intérieur et des services d’intérêt économique général’, *Révue du Droit de l’Union Européenne* (2006), 23–50.

¹¹¹ Case C-107/98, *Teckal* [1999] ECR I-8121. ¹¹² *Ibid.*

¹¹³ 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, for example, Case C-367/98, *Commission v. Portugal* [2002]

a special right is conferred is used to finance a contiguous service of general interest).¹¹⁴ The Procurement Directives are not applicable to the award of such contracts,¹¹⁵ 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 section two, subsection C. 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 outcome seems to stem from the Court’s judgment in *Glöckner*,¹¹⁶ where the Court admitted that extending the duration of previous special rights for ambulance and transport services did not require a tendering procedure. This part of the Court’s judgement, however, is very laconic and obscure, and may have been overturned by the more recent and more peremptory judgement in *Placanica*.¹¹⁷ It should be noted that, in this case, the Court held that even the revocation and redistribution by public tender of authorizations may be required in order to make up for the violation of the Treaty rules. Hence, it is not clear whether ‘closed processes’ are allowed and under what circumstances.

Open awards

In contrast, on 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 health care, this practice is quite wide-spread, since in many Member States all physicians and/or all hospitals that fulfil several criteria may be contracted into the public health care system. This is true for physicians in Belgium, Hungary, Greece, the United Kingdom 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 authorization, since everyone who fulfils

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.

¹¹⁴ See Case C-320/91, *Corbeau* [1993] ECR I-2562; Case C-393/92, *Almelo* [1994] ECR I-1477; Case C-475/99, *Glöckner*, above n.67.

¹¹⁵ Article 18, European Parliament and Council Directive 2004/18/EC, above n.9.

¹¹⁶ Case C-475/99, *Glöckner*, above n.67.

¹¹⁷ Joined Cases C-338/04, C-359/04 and C-360/04, *Placanica*, above n.50.

the conditions set in advance should be awarded a contract. Hence, the case-law of the Court on the delivery of authorizations 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.¹¹⁸

Competitive awards

Finally, there are cases where a proper competitive tender is to be held. This is what should happen in Italy, the United Kingdom, Hungary and Greece when the relevant public authorities or trusts need to contract with 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 should be noted that ‘health and social services’ are enumerated in Annex IIB of the Directive and are only subject to a partial application of its rules. The only Directive provisions that are applicable to the Annex IIB 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.¹¹⁹ For the rest, the contracting entity is free to follow the award procedure of its choice, provided this satisfies the general ‘procurement criteria’ recognized 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, *inter alia*, 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 that 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

¹¹⁸ See, among many, Case C-157/99, *Geraets Smits and Peerbooms*, above n.1.; C-368/98, *Vanbraekel* [2001] ECR-I-5363.

¹¹⁹ Article 21, European Parliament and Council Directive 2004/18/EC, above n.9. Mixed contracts (which involve the provision of both health care and other Annex II A services) should be awarded on the basis of the contract having the most important value. See Article 22, Directive 2004/18/EC. See also the Court’s judgment in Case C-475/99, *Glöckner*, above n.67.

this 'Framework' could and should affect the procurement practices of health care entities remain to be tested before the national courts and, ultimately, the ECJ.

4. Conclusion

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

Health care 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 are developing advanced accounting methods and managerial independence. This transition, pregnant with political, economic and legal uncertainties, explains the malaise in applying the EC rules. Rules that are designed to regulate different situations and that, 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 health care 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, I 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 aid on the organization and functioning of national health care systems'.¹²⁰ 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 aid, under given circumstances. However, the *Altmark* conditions are too demanding and, in practice, are very rarely fulfilled. Further action may be required by the Commission in the form of a block exemption regulation from Article 81 EC for health care

¹²⁰ Hatzopoulos 'Health law and policy', above n.1, p. 168.

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 health care 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 health care systems.

How deeply the EC rules on public procurement and on state aid are going to affect the organization 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.¹²¹

Concerning regulatory technique, in policy fields where hard law (the harder you can get: state aid 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 had recourse to soft law in the field of state aid and, recently, also in the field of public procurement (see, for example, the *de minimis* Communication on procurement).¹²² Second, that under pressure from technological development, economic realities and EC law, Member States are aware of the fact that inertia is not a policy option in the field of health care. Dynamism thus inflicted could be steered towards a convergence 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'.¹²³ The fact that the part of the sentence in quotation marks is directly copied from the Lisbon Treaty provision dealing with 'Public Health' clearly indicates that this is a road that 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

¹²¹ See a first assessment by G. Davies, 'The process and side-effects of harmonisation of European welfare states', Jean Monnet Working Paper No. 02/06 (2006), pp. 1–64.

¹²² European Commission, 'Interpretative Communication', above n.47. On the use of soft law in the field of health care in general, see Chapter 4 in this volume.

¹²³ Article 168(2), Consolidated Version of the Treaty on the Functioning of the European Union, OJ 2008 No. C115/1.

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 provides, in similar, but perhaps stronger, terms to those of Article 152(5) EC, 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 organization 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', the Commission's initiatives are subject to strong scrutiny.

The use of soft law and soft coordination, combined with the absence of strong steering from the Commission, make the impact of the EU rules on national health care systems very difficult to foresee. For this reason, retrospective analysis of the impact of the former on the latter becomes all the more important.