# FINANCING NATIONAL HEALTH CARE IN A TRANSNATIONAL ENVIRONMENT: THE IMPACT OF THE EUROPEAN COMMUNITY INTERNAL MARKET

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## ABSTRACT

In the European Union (EU) there are as many health care systems as there are states. However, if there is one characteristic in common among the various European systems, it is (the objective of) universal health care coverage. This article first presents the manner in which the objective of universal coverage in health care has come into existence in the different Member States. A brief discussion then follows of the basic health care models put into work by the Member States which makes it clear that the common backbone of all the national health systems is the principle of solidarity. Solidarity supposes community of identity, or at least of interest, between the people concerned and has traditionally been perceived as a nation bound principle. This notwithstanding, the European Union has undertaken action in the field of health care and has gradually come to recognize that health care services fall within the ambit of the European Community Treaty (EC Treaty). Therefore, not only should the free movement of professionals and patients be assured, but the Treaty rules on competition, state aids, and public procurement should, in principle, also be respected. This, in turn, raises the acute problem of financing health care—which is traditionally based on factors such as massive fund transfers, subsidies, and direct award contracts—especially at a time where state funding becomes increasingly scarce. To appreciate the impact of the European Community rules, the tight interplay knit by the European Court of Justice between the rules on state aid and on public procurement must first be unfolded. Only then can the actual or potential impact of the European Community

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rules on various aspects of the organization and financing of health care be put forward.

## I. INTRODUCTION

In the United States (U.S.), people often speak of the "European Social Model," as if such a model actually existed.[1] In Europe, authors tend to use subtle qualifications each time they refer to this particular concept. If one were to look into the social model of every individual Member State, very important differences would emerge. These differences would be further exaggerated by the divergent rules and practices followed across Europe. Nevertheless, there is at least one overarching principle shared by all Member States' social models which could quali-

[1] The term was first used by the EC Commission in a White Paper under the instigation of then President Jacques Delors. *Commission White Paper, European Social Policy-A Way Forward for the Union*, COM (1994) 333 final (July 27, 1994). *See also* Jacques Delors, *Conclusions: Defending the European Model of Society*, *in* COMBATING SOCIAL EXCLUSION, FOSTERING INTEGRATION 48, 48-49 (1992), where this model is defined through a mixed economy with the participation of all citizens, where market forces are combined with government and social dialogue. The 2003 Greek Presidency called an International Conference which led to the publication of a lengthy general report, see CONNECTING WELFARE DIVERSITY WITHIN THE EUROPEAN SOCIAL MODEL (Theodoros Sakellaropoulos & Jos Berghman eds., 2004). In the same vein, see Fritz Scharpf, *The European Social Model: Coping with the Challenges of Diversity*, 40 J. COMMON MKT. STUD. 645 (Peter Lang 2002) and Jo Shaw, *A Strong Europe is a Social Europe*, The Federal Trust (Feb. 2003), *available at* http://www.fedtrust.co.uk/uploads/constitution/05_03.pdf. After seriously questioning the existence of a European social model, several writers have answered in the affirmative, Elias Mossialos & Martin McKee, *A European Social Model, in* EU LAW AND THE SOCIAL CHARACTER OF HEALTH CARE 27, 31-32 (2002) and, more recently, Daniel Wincott, *The Idea of the European Social Model: Limits and Paradoxes of Europeanization*, *in* THE POLITICS OF EUROPEANIZATION 279, 280 (Kevin Featherstone & Claudio Radaelli eds., 2003). In recent years, some writers have raised the issue of the externalities produced by the European social model, *see, e.g.*, Assar Lindbeck, Asian Development Bank, The European Social Model: Lessons for Developing Countries (2002), *available at* http://www.adb.org/Documents/ERD/Working_Papers/wp011.pdf. However the very existence of a (single) social model has been questioned by many writers in view of (a) the considerable divergences in the social stratification and the organization of the social services in the member states, *see, e.g.*, McKee & Mossialos, above, and (b) the secondary role that social matters play in the EU's common policies, *see, e.g.*, Christian Joerges & Florian Rödl, *"Social Market Economy" as Europe's Social Model?*, (Eur. Univ. Inst., Working Paper No. 2004/8) and Christian Joerges, European Integration Online Papers, The Market Without the State? The "Economic Constitution" of the EC and the Rebirth of Regulatory Politics (1997), *available at* http://eiop.or.at/eiop/pdf/1997-019.pdf. The debate is still open, both at the academic and at the political level. *See* Lorraine Mullally & Neil O'Brien (eds.), Beyond the Social Europe (2006), *available at* http://www.openeurope.org.uk/research/fullbook.pdf and Poul Nyrup Rasmussen & Jacques Delors, The New Social Europe (2007), *available at* http://www.pes.org/downloads/NSE_Web_interactive_EN.pdf.

fy as the cornerstone of the "European Social Model," the objective of universal coverage.

Part I of this article begins by examining how the objective of universal health care coverage has materialized in the various Member States of the European Union (EU). The great variety of national rules and practices reduces this article's scope to a basic presentation of general health care models. Part II identifies the backbone of all European systems which is the principle of solidarity. Solidarity supposes a community of identity, or at least of interest, between the people concerned and is traditionally a nation bound principle. Nevertheless, the European Commission has undertaken action in the field of health care and has gradually come to recognize that health care services fall within the ambit of the European Community Treaty (EC Treaty). Therefore, both the free movement of professionals and patients should be assured and the EC Treaty rules on competition, state aids, and public procurement should also, in principle, be respected. Part III of the article discusses the acute problem of financing health care—which is traditionally based on factors such as massive fund transfers, subsidies, and direct award contracts—during a time when state funding has become increasingly scarce. Part IV of this article explores of the European Community (EC) rules. In order to appreciate the impact of the relevant EC rules, it is necessary to first unfold the tight relationship between the rules on state aid and on public procurement as established in the case law of the European Court of Justice (ECJ). Part V discusses the actual or potential impact of the EC rules on various aspects of the organization and financing of health care. Finally, Part VI concludes as to how EU rules can be utilized to accommodate the needs of health care.

## II. SOLIDARITY UNFOLDED: THE MAIN NATIONAL HEALTH CARE MODELS OF EUROPEAN UNION MEMBER STATES

### A. UNIVERSAL COVERAGE AND THE SETUP OF HEALTH CARE

In the field of health care, universal coverage corresponds to more than a mere application of a "model." Universal health care is

guaranteed by the national constitutions of most Member States[2] and, arguably, by several international human rights charters or conventions to which the European states are signatories.[3]

Universal health care, in turn, requires that the minimum requirements of coverage and accessibility are met. The three main requirements that any "universal" health care system should satisfy are: full territorial coverage, full personal coverage, and equal terms of access for all.

These objectives are purely "health" objectives; they concern the existence of infrastructures, the qualifications of health professionals, the development of adequate treatments, and the physical access of the population to the above. The "insurance" question (i.e., who should pay and how payment should be made in regards to the above mentioned factors) is a distinct—and at least as acute—problem.

In turn, the fulfillment of these health objectives require some detailed planning concerning: the availability of the necessary infrastructure (fixed and consumable) duly scattered around the relevant territory, the maintenance of an adequate ratio between both the available facilities and health practitioners and the population to be covered, and the existence of a full scope of the medical specializations within the relevant territory.

The aforementioned requirements may not be completely fulfilled without some degree of state financing, as private initiatives tend to concentrate on urban zones and on highly profitable diseases and their cures. The way the state responds to such requirements are linked to factors including: the geographic and climatic characteristics of each state, the particular health trends of the respective states' population, budgetary constraints, and the degree to which disease and suffering is socially accepted in each state. What is clear, however, is that some state planning of health care is indispensable (in order to ensure universal coverage). Planning normally takes place at the national level (in order to cover the national population, according to national needs) and for the purposes of

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[2] *See, e.g.*, THE CONSTITUTION OF THE REPUBLIC OF HUNGARY, art. 70/D(1), and in less compelling formulation, THE CONSTITUTION OF THE KINGDOM OF THE NETHERLANDS, art. 22(1), THE CONSTITUTION OF THE ITALIAN REPUBLIC, art. 32, THE BELGIAN CONSTITUTION, art. 23(2), and THE GREEK CONSTITUTION, art. 21(3).

[3] For a very interesting discussion about the existence of a generally recognized "right to health" and the effects thereof, see Tamara Hervey, *The "Right to Health" in European Union Law, in* ECONOMIC AND SOCIAL RIGHTS UNDER THE EU CHARTER OF FUNDAMENTAL RIGHTS-A LEGAL PERSPECTIVE 193, 198 (Tamara Hervey & Jeff Kenner eds., 2003).

implementation state planning cannot rely exclusively upon private initiatives but also requires state financing to a variable extent.

It becomes clear, therefore, that the founding, administering, and financing of a health care system are essentially national and/or state issues and that any external interference may only be a source of perturbation.

## B. UNIVERSAL COVERAGE AND THE FUNDING OF HEALTH CARE: SOCIAL HEALTH CARE

A health care system that is accessible to all is of no use if all people do not possess the financial means to access to it. This is why the health care system is intrinsically linked to the system of social coverage applicable in every EU state. The extent to which any given person has access to a state's health care system, in the form of a social benefit, is aptly referred to as "social health care." The scope of social health care varies greatly from state to state, but it is commonly defined by the variables of three main parameters: personal scope, the scope of treatment, and the scope of implementation.[4]

The personal scope primarily asks, "Who is covered?" Here the starting point is universal coverage, but it may also be subject to certain exceptions, essentially in favor of better-off categories (such as the high-earners, the self-employed and civil servants in Germany, or high-earners and the self-employed in the Netherlands).[5]

The scope of treatment, asks, "What is not covered?" In this respect, there are important differences between the various states since some treatments and/or surgeries may be covered in some states while in other states they are completely illegal. Examples of treatments that may or may not receive coverage include: abortions, cosmetic surgeries, and sex reassignment operations. The same is applicable for drugs and pharmaceuticals for which some social health care systems have specific black/white lists that explain which drugs that are covered and which are not, while others cover all of them without distinction.

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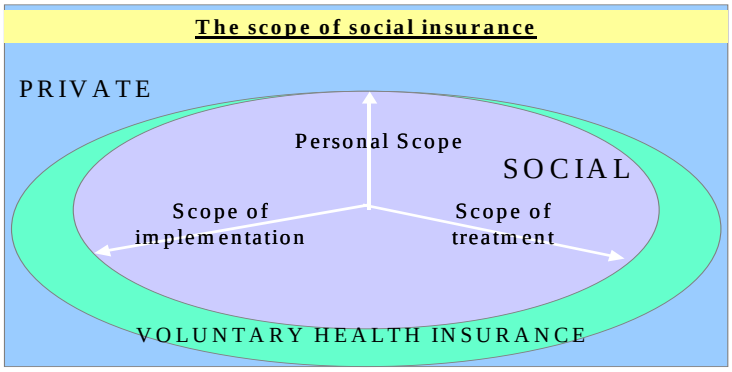
[4] The presentation of the three variables defining the scope of Social Healthcare is essentially due to Jason Nickless, *The Internal Market and the Social Nature of Health Care*, *in* THE IMPACT OF EU LAW ON HEALTH CARE SYSTEMS 57, 64 (Martin McKee et al. eds., 2002), where the reader is encourage to refer for further details.

[5] *See* Willy Palm, *Voluntary Health Insurance and EU Insurance Directives: Between Solidarity and the Market*, *in* McKee et al, *supra* note 4, at 195, 199. The percentage of those not covered by the compulsory Social Healthcare scheme is evaluated to 9% and 31% in Germany and the Netherlands, respectively.

The scope of implementation pertains to who may provide health care services covered by the social health care system. In this respect, the crucial distinction is made between outpatient treatment and hospital treatment. Both are, in principle, covered, but under different conditions (e.g., application of the devolution principle, according to which specialized laboratory exams or surgery are not paid for unless prescribed by a general practitioner).

For health services or patients who fall outside the scope of social health care (or decide to opt out), as defined by the interplay of the three aforementioned variables, coverage may be offered by "voluntary" or "additional" health insurance options, typically offered by mutual funds and private insurers. Finally, for those who are not covered by the above, the private sector offers all sorts of tailor-made health care coverage.[6]




As far as social health care is concerned, the European standard is universal coverage.[7] However, a survey of the social health care systems of the Member States identifies a number of distinct systems.[8] Neverthe-

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[6] *See, e.g.*, Sarah Thomson & Elias Mossialos, *Regulating Private Health Insurance in the European Union: The implications of Single Market Legislation and Competition Policy*, 29 J. EUR. INTEGRATION, 89.

[7] *See infra* Part II.B.3.

[8] For a general but comprehensive overview, see Yves Jorens, *The Right to Healthcare Across Borders*, *in* McKee et al, *supra* note 4, at 83, 84.

less, aside from the shared essential feature of universal health coverage, there are few other common qualities that the Member States systems' share. The distinct health systems can be seen as the specific emanations of the two broad models of social health care known, after the names of their founders, as the Bismarkian model or the Insurance Health System and the Beveridgeian model or the National Health System.[9] Moreover, all the distinct national systems may be classified into two broad categories, depending upon whether they ensure patients treatment for free or reimbursement.[10]

### 1. CONTRIBUTION VERSUS TAX BASED SYSTEMS

The first model of the social insurance system was promoted and established in Germany during the 1870s by Chancellor Bismarck. It followed a participative pattern inspired by the professional corporations of the Middle Ages. Under this system people are insured because of their participation in a professional group, organization, industry, or firm. Complementary schemes are put into place to cover those (essentially inactive people) who do not come under any of the sector-specific schemes. The result is a multitude of funds, public or private, each operating slightly differently from the other, financed by direct contributions of both the employer and the employee. Under this model, global planning and advanced coordination of the overall health care capacities is quite complicated. Hospitals, clinics, or other health care establishments and facilities are either public or private (contracted by the state). Today, the Bismarkian model or Insurance Health System is found in Austria, France, Germany, and the BENELUX countries—Belgium, the Netherlands, and Luxembourg.

In 1942, William Beveridge, a British economist and social reformer, submitted the famous "Beveridge Report" on Social Insurance and Allied Services, to the British Ministry of Health.[11] The starting point of the Beveridge model was universal coverage. Under the Beveridge model, people are insured not because of some sort of direct or indirect participation in a profession or other specific category; rather, people are insured by virtue of their citizenship and/or physical presence on national territory (thus the title "national" health system as opposed to

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[9] *See infra* Part II.B.1.

[10] *See infra* Part II.B.2.

[11] SIR WILLIAM BEVERIDGE, SOCIAL INSURANCE AND ALLIED SERVICES (1942), *available at* http://news.bbc.co.uk/2/shared/bsp/hi/pdfs/19_07_05_beveridge.pdf.

the "insurance" health system). There is a single fund (or even no fund at all), which is financed directly by the state, through taxes, and other direct or indirect contributions. The existence of a single fund allows for more detailed planning and coordination of health care facilities (notably with a strict division of the three levels of health care and a consistent application of the devolution principle), which are essentially public.[12] The Beveridge model, or the National Health System, is followed in the United Kingdom, Ireland, Denmark, Finland, Sweden, and in the "Mediterranean" countries of Spain, Portugal, Italy, and Greece.[13]

### 2. REFUND VERSUS BENEFITS-IN-KIND SYSTEMS

From the perspective of benefits accruing to patients, European social health care systems can be classified into two broad categories: the refund system and the benefits-in-kind system.

The refund system allows patients to receive treatment from any practitioner/institution of their choice and then offers reimbursement (partial or complete) for the expenses incurred. In this system, the patient has a wide range of choices since he or she may opt for any practitioner and/or hospital, irrespective of whether it is public or private, the types of techniques that are utilized, and the prices that are charged.

In the benefits-in-kind system, patients are directed to specific practitioners or hospitals/clinics—either public or private who contracted into the social health care system—where they are treated "for free." Where treatment is offered by public undertakings, the expenses are directly covered by the state budget. Contracted private undertakings, on the other hand, usually receive a flat annual fee (calculated for example, based on the number of people they intend to cover) and a fee per capita of patients treated, plus actual expenses incurred. In this system, patient choice is more restricted, particularly where their only choice is public doctors and hospitals; health is seen more as a public good to which access should be ensured in all circumstances and less as a commodity or good for which the consumer/patient may have a say.

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[12] *Id*. at 8.

[13] *See* GEORGE KATROUGALOS & GABRIELLA LAZARIDIS, SOUTHERN EUROPEAN WELFARE STATES: PROBLEMS, CHALLENGES AND PROSPECTS 123 (2003) for a recent discussion on whether there is, indeed, such a thing as a "Mediterranean" model for the organization of social welfare. Before that, see Maurizio Ferrera, *The Southern Model of Welfare in Social Europe*, 6 J. EUR. SOC. POL'Y 17-37 (1996) and Elias Mossialos, *Citizens' Views on Health Care Systems in the 15 Member States of the European Union*, 6 HEALTH ECON. 109, 110 (1997).

The dichotomy between the reimbursement and the benefits-in-kind systems does not coincide with the distinction between the Bismarkian and the Beveridge models. Indeed, it is true that all countries following the latter model do operate a system of benefits-in-kind. The same is true, however, for some countries following the Bismarkian model, such as Austria, Germany, and to some extent the Netherlands, where contracted private hospitals and practitioners treat patients without them incurring "out of the pocket" expenses. The refund system is followed in France, Belgium, and Luxembourg.

### 3. CONVERGENCE POINT: THE PRINCIPLE OF SOLIDARITY

The development and numerous variations of all the systems mentioned above should not mask the existence of a core principle governing social health care which sharply distinguishes Europe from other continents: universal coverage. Universal coverage has served more as a guiding principle rather than a tangible reality, since in many "advanced" countries, such as France, it has been achieved only fairly recently,[14] while in the Mediterranean countries it is not clear whether it has been fully achieved[15] (the continuing migration from third countries, essentially illegal, ascribes a new dimension to the issue of universal coverage).

In the field of health care, universal coverage itself is a manifestation of the principle of solidarity—one of the great values inherited by the French Revolution. Solidarity in health care is also justified in economic terms by the existence of important information asymmetries.[16] In the organization of social health care in Europe, the principle of solidarity is pervasive. It may be located on at least three levels:[17] integration into the system, funding of the system, and benefits ensured by the system.

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[14] *See, e.g.*, Law No. 99-641 of July 27, 1999, Journal Officiel de la République Française [J.O.] [Official Gazette of France], July 28, 1999, p. 11229, which instituted the "Couverture Maladie Universelle" with the same characteristics. In Belgium, the Royal Decree extending statutory health insurance to all people legally residing in the country and not entitled to coverage under any other Belgian or foreign system was adopted on April 25, 1998. In both schemes, contributions are due only by people exceeding a certain level of income. *See* HEALTH CARE SYSTEMS IN TRANSITION: BELGIUM, EUROPEAN OBSERVATORY ON HEALTH CARE SYSTEMS 78 (2000).

[15] KATROUGALOS & LAZARIDIS, *supra* note 13, at 2-3.

[16] *See* George A. Akerlof, *The Market for "Lemons": Quality Uncertainty and the Market Mechanism*, 84 Q.J. ECON. 488 (1970) for the way in which information asymmetries prevent the market operation.

[17] *See* Palm, *supra* note 5, at 196-197 for these three levels of analysis of the principle of solidarity.

In terms of the integration into the system, three main characteristics speak of solidarity: universality (i.e., the inclusion of all people into the system), mandatory affiliation, (i.e., the fact that opting out is, in principle, prohibited—subject to specific exceptions), and mandatory acceptance, (i.e., the fact that the fund[s] may not exclude some categories of persons or of risk).

In terms of funding the system, another three characteristics are dictated by solidarity: contributions are income-related so that the categories that are better-off have more significant input into the system; contributions are independent from individual risk factors such as age, sex, health history, habits, occupation; and some permanently loss-making schemes (especially those covering high-risk or low-income activities) are maintained through cross-subsidization by others.

In terms of benefits ensured by the system, the principle of solidarity is embodied in, at least, two manifestations. First, all patients receive equal treatment, irrespective of their personal, financial, professional situations (and irrespective of how much they have contributed into the system). Second, coverage is progressive according to the medical needs of each patient.

The fact that solidarity is the core concept underlying any system of social health care has two consequences. First, the national character of social health care comes to the forefront—it is difficult to expect people from one state to feel solidarity (and to give away part of their income) to people from other states. Second, the application of market principles in a field governed by solidarity—and where market failures inevitably result from the important information asymmetries—may not be without problems.

## III. HEALTH CARE AS A SERVICE UNDER THE EUROPEAN COMMUNITY TREATY RULES: THE GRADUAL EUROPEAN UNION GRIP

### A. LIMITED EU COMPETENCE FOR HEALTH CARE

Though solidarity can be seen as a fundamentally national attribute, the EU has undertaken action in the field of health care. The EU has done so even before any express (or modest) legal basis was in-

troduced into the 1992 Maastricht Treaty.[18] Article 152 of the EC Treaty on public health, as it stands after the 1997 Amsterdam Treaty, has served as the legal basis for several measures accompanying and coordinating national health policies; this has been accomplished by programs that fund specific research or dissemination activities, treatments, and population target groups.[19] It should also be noted that European Community action in the field of health, even after the entry into force of the Lisbon Treaty, would primarily be (1) complementary and supportive action taken by Member States, (2) place greater focus on promotion and prevention rather than on health care, (3) will only rarely lead to any form of harmonization, and (4) provide that the principle of subsidiarity is respected.[20]

### B. EC MEASURES AFFECTING HEALTH CARE

The health care policy of the Member States is directly affected by rules which pursue other mainstream EC objectives. Three categories of measures may be identified in this respect.

The first category of measures which directly impacts the health care policy of Member States are measures that are adopted in view of the achievement of the free movement of workers, free provision of services, and the freedom of establishment. Their legal basis is found in the Title III of the EC Treaty (Articles 39 *et seq.*), and is occasionally strengthened by Article 308 (ex 235). These measures have been provided for by the General Programs[21] and may be classified into two broad categories: instruments which aim to ensure that workers who are moving within the European Community continue to receive social and health care benefits[22] and instruments which organize the equivalence and mutual

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[18] In relation to the issue of the legal basis for health issues, see Tamara Hervey, *The Legal Basis of EC Public Health Policy*, *in* McKee et al, *supra* note 4, at 23-26.

[19] *Id*. at 25-27, 28-32.

[20] *See* Treaty of Lisbon amending the Treaty on European Union and the Treaty establishing the European Community, art. 127, Dec. 13, 2007, 2007 O.J. (C 306).

[21] 1962 O.J. (L 62) 32-36.

[22] Council Regulation 1408/71 on the Application of Social Security Schemes to Employed Persons, to Self-Employed Persons and to Members of their Families Moving within the Community, 1971 O.J. (L 149). This regulation has been modified at least thirty times, the last important modification extending its personal scope to cover nationals of non-member states legally residing within the EU. *See also* Council Regulation 859/2003 extending the Provisions of the Regulation (EEC) No. 1408/71 and Regulation (EEC) No. 574/72 to Nationals of Third Countries who are Not Already Covered by Provisions Solely on the Ground of their Nationality, 2003 O.J. (L 124) 1 [hereinafter Council Regulation No. 859/2003]. It has recently been codified and re-

recognition of diplomas and other qualifications for the cross-border provision of health care services.[23]

The second category deals with measures aimed at ensuring the free movement of goods, especially drugs and medical devices.[24] An outer circle in this category is constituted by European Community measures concerning general product safety rules and labeling.[25]

The third category pertains to measures ensuing from other policy fields of the EU that may be directly related to health. It should be noted that the precautionary principle, which is aimed specifically at the protection of health, was recognized as having the status of a general principle of European Community law in a series of cases related to the application of the Common Agricultural Policy.[26] It is also applicable to environmental policy.[27] Moreover, measures adopted for the implementation of Title IV of the EC Treaty (immigration policy) or those of third pillar policies (i.e., police and judicial cooperation and issues on foreign and security policy) may also relate to health protection.[28]

Thus, despite the fact that the European Community lacks the competence to intervene directly in the field of health care services, there are a number of specific measures which have the authority to either coordinate or harmonize issues directly linked to the administration of health care services. However, there is no way in which these texts may account for the actual impact of European Community law on national

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pealed by Regulation 883/2004 on the Coordination of the Social Security Systems, 2004 O.J. (L 166) 1, art. 90. Since all the legislative and judicial developments of the present contribution relate to Regulation 1408/71, references will be made to this legislative instrument.

[23] These directives cover (a) general practitioners and doctors, (b) nurses, (c) dentists, (d) veterinary medicines, (e) midwives, and (f) pharmacists. The other peripheral professions fall under the catch-all umbrella of the "general systems" for the recognition of professional qualifications. All these are now regulated by the catch-all Directive 2005/36/EC on the Recognition of Professional Qualifications, 2005 O.J. (L 255). Those who do not fall in any of the categories covered by the directive may still benefit from the general case law of the ECJ on mutual recognition of professional qualifications. *See, e.g.*, Case C-234/07, Fernández de Bobadilla v. Museo Nacional del Prado, 1999 E.C.R. I-4773.

[24] *See* Leigh Hancher, *The Pharmaceuticals Market: Competition and Free Movement Actively Seeking Compromise*, *in* McKee et al, *supra* note 4, at 254-55 and Christa Altenstetter, *Regulation of Medical Devices in the EU*, *in* McKee et al, *supra* note 4, at 281, 290-301.

[25] For a brief overview of these measures, in relation to healthcare, see Hancher, *supra* note 24 and Altenstetter, *supra* note 24.

[26] *See* Case C-180/96R, U.K. v. Comm'n, 1996 E.C.R. I-3903, *aff'd* 1998 E.C.R. I-2265 and Case T-75/98, Nat'l Farmers' Union v. Comm'n, 1996 E.C.R. II-815, *aff'd* E.C.R. I-2211.

[27] *See* Communication from the Commission on the Precautionary Principle, at 3-5, COM (2000) 1 final (Feb. 2, 2000), *available at* http://ec.europa.eu/dgs/health_consumer/library/pub/pub07_en.pdf.

[28] See, in this respect, the extension of the personal scope of Regulation 1408/71 to cover third country nationals, Council Regulation No. 859/2003, *supra* note 22.

health care systems. The decisive factor in this direction has been the direct application by the ECJ of the general EC Treaty rules on the internal market to the provision of health care services.

### C. HEALTH CARE AS A SERVICE UNDER THE TREATY: FREE MOVEMENT OF PATIENTS

In order to make the limited movement of capital possible at a time when the relevant Treaty freedom was completely idle, the ECJ held that payments for services received in another Member State should be free of any restriction.[29] By the same token, the Court recognized that medical patients, students, and tourists moving to another Member State are service recipients within the meaning of Article 49 of the EC Treaty and should be allowed to carry around the money necessary to cover such services.[30]

In this indirect and almost unconscious way the ECJ has established that health care services constitute services for the purposes of the Treaty.[31] This has led to spectacular developments in the last seven years. This case law, which is lengthy, highly technical, and politically controversial has been presented in detail by several authors and does not need to be reviewed again here.[32] However, it should be noted that a patient from any Member State who moves abroad, may, in addition to ur-

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[29] Joined Cases 286/82 & 26/83, Luisi and Carbone v. Ministero del Tesoro, 1984 E.C.R. 377.

[30] *Id*.

[31] The same conclusion was also reached by the Court in Case C-159/90, Soc'y for the Prot. of Unborn Children Ir. Ltd. v. Grogan, E.C.R. I-4685. In this case however, the Court avoided applying the relevant Treaty rules, as it was unable to identify any consideration for the services offered. *Id.*

[32] *See* Vassilis Hatzopoulos, *Killing National Health and Insurance Systems but Healing Patients? The European Market for Health Care Services after the Judgments of the ECJ in Vanbraekel and Peerbooms*, 39 COMMON MKT. L. REV. 683 (2002) and, more recently, Vassilis Hatzopoulos, *Health Law and Policy: The Impact of the EU*, *in* EU LAW AND THE WELFARE STATE: IN SEARCH OF SOLIDARITY 111 (Grainne De Burca ed., 2005). *See also* Gareth Davies, *Welfare as a Service*, 29 LEGAL ISSUES OF EUR. INTEGRATION 27 (2002); Pedro Cabral, *The Internal Market and the Right to Cross-Border Medical Care*, 29 EUR. L. REV. 673 (2004); Anne Pieter van der Mei, *Cross-Border Access to Health Care within the European Union: Recent Developments in Law and Policy*, 10 EUR. J. HEALTH L. 369 (2003); and Anne Pieter van der Mei, *Cross-Border Access to Medical Care: Non-Hospital Care and Waiting Lists*, 31 LEGAL ISSUES OF ECON. INTEGRATION 57 (2004). More recently, see Anthony Dawes, *"Bonjour Herr Doctor:" National Healthcare Systems, the Internal Market and Cross-Border Medical Care within the European Union*, 33 LEGAL ISSUES OF ECON. INTEGRATION 167 (2006). For a full account of the relationship between EU and Health Law, see generally TAMARA HERVEY & JEAN MCHALE, HEALTH LAW AND THE EUROPEAN UNION (2004).

gent treatment provided by virtue of the European Insurance Card (ex Document E 111)[33] may also:

- Receive outpatient treatment[34] in any other Member State and obtain a refund from their home state at the tariffs applicable in the latter state; no prior authorization is necessary for such a refund to be obtained, since the relevant right stems directly from Article 49 of the EC;
- Receive any kind of treatment in other Member States subject to the same conditions (i.e., tariffs, refunds, and indemnity—but for the duration of the treatment) as patients of the host state, provided that they have obtained prior authorization (document E 112) by their home institution, according to Article 22 of Regulation 1408/71;
- Require the delivery of the above authorization (for receiving treatment abroad) whenever the treatment, objectively necessary for their medical condition, [35] is not available in their home state or is not available within a reasonable period of time, taking into consideration the specific needs of each particular patient;[36] this is also a right stemming directly from Article 49 of the EC.

These rights benefit all people insured with the competent institution of one Member State, irrespective of whether their home state:[37] operates a refund system (followed principally in France, Germany, and Luxembourg);[38] operates a benefits-in-kind system by contracted-in physicians and hospitals (i.e., the Netherlands);[39] or offers benefits-in-kind through essentially public institutions (i.e., the United Kingdom and Italy).[40]

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[33] The E111 was a harmonized document distributed by national insurance funds and recognized all over Europe, whereby patients could obtain treatment in other Member States.

[34] Inpatient treatment has been restrictively defined, see Case C-8/02, Leichtle v. Bundesanstalt für Arbeit, 2004 E.C.R. I-2641.

[35] *See* Case C-376/98, Vanbraekel v. ANMC, 2001 E.C.R. I-5363, I-5402-03, for the objective assessment of the necessity of the treatment independent from national preferences.

[36] Case C-385/99, Müller-Fauré v. Onderlinge Waarborgmaatschappij OZ Zorgverzekeringen, 2003 E.C.R. I-4509, I-4570-72, I-4579 and Case C-372/04, Watts v. Bedford Primary Care Trust, 2006 E.C.R. I-4325, I-4426-27.

[37] The threefold classification which follows is simplistic, for the needs of demonstration, and does not account for the special characteristics of each one of the national systems.

[38] *See* Case C-158/96, Kohll v. Union des Caisses de Maladie, 1998 E.C.R. 1-1931, I-1950-51; Case C-56/01, Inizan v. Caisse primaire d'assurance maladie des Hauts-de-Seine, 2003 E.C.R. I-12403, I-1246; Case C-193/03, Bosch v. Bundesrepublik Deutschland, 2004 E.C.R. I-9911, I-9924.

[39] Case C-157/99, Smits & Peerbooms, 2001 E.C.R. I-5473, I-5529; Vanbraekel, 2001 E.C.R. I-5363; and Müller-Fauré, 2003 E.C.R. I-4509.

[40] Watts, 2006 E.C.R. I-4325, at I-4408-09.

As a consequence of the aforementioned case law,[41] mobility of patients across the EU countries has been greatly facilitated. However, to date, this has not resulted in a dramatic increase of patients who pick and choose health care services in various Member States.[42]

The case law discussed undeniably establishes that health care services do fall within the scope of the EC Treaty. The objective of universal coverage, the principle of solidarity, the need for planning, and other related concerns are only relegated to issues that justify the occasional setting aside of the EC rules. This is done on a case by case basis and in a way that is respectful of the principle of proportionality.

The recognition, by the ECJ, that health care services are services within the meaning of the Treaty, has very important legal implications, most of which have yet to materialize. Free movement of patients is just the tip of the iceberg. Far more crucial than accommodating the few thousands of "peripatetic" patients moving from one state to another is the issue of financing high performance health care systems that possess universal coverage. In an era of contractualized governance in the delivery of public services,[43] where the "providential state" gives way to the "regulatory state,"[44] and where public spending containment is an absolute value, the need for public funding for health care is still not seriously put into question.[45] 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 '90s the debate concerned anti-competitive practices and Article 82 EC . . . since the beginning of this millennium, the main question has shifted to the means of financing public services and state aids."[46]

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[41] *See generally* HATZOPOULOS, *Health Law and Policy*, *supra* note 32, for a comprehensive presentation of the relevant case law and its implications for the organization of health services in the member states.

[42] *See* HERVEY & MCHALE, *supra* note 32, at 143-44.

[43] Christopher H. Bovis, *Financing Services of General Interest in the EU: How do Public Procurement and State Aids Interact to Demarcate between Market Forces and Protection?*, 11 EUR. L.J. 79, 90-92 (2005).

[44] *See generally* Giandomenico Majone, *The Rise of the Regulatory State in Europe*, W. EUR. POL., 17:3 (1994), at 77, and Francis McGowan & Henry Wallace, *Towards A European Regulatory State*, 3 J. EUR. PUB. POL'Y 560 (1996).

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

[46] Laurence Idot, *Concurrence et Services d'Intérêt Général Bref Bilan des Évolutions Postérieures au Traité d'Amsterdam, in* LES SERVICES D'INTÉRÊT ÉCONOMIQUE GÉNÉRAL ET L'UNION EUROPÉENNE 39, 41 (Jean-Victor Louis & Stéphane Rodrigues eds., 2006).

Hence, public funds have to be given out either by following a competitive tender based on objective and transparent criteria or be individually evaluated under the Treaty rules on state aids.

In Part IV of the article, an attempt will be made to clarify the close interplay between the two sets of rules, as put forward by the recent case law of the European Court of Justice. Then the concrete practical implications that the European Community rules may have on the provision of health care services will be examined

## IV. PUBLIC PROCUREMENT AND STATE AID: A CLOSE COUPLE

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.[47]

### A. LOGICAL LINKS BETWEEN STATE AID AND PUBLIC PROCUREMENT

First, there is a logical link. When public authorities wish to favor specific players in a given market, they can do so in two ways: directly—by giving them public subsidies, or indirectly—by awarding to them public contracts. Hence, both sets of rules are designed to prevent the public authorities from unduly interfering with markets. The rules on state aid[48] prohibit such money infusions unless they are specifically "declared compatible" by the Commission following a notification procedure. The rules on public procurement, on the other hand, set in Directives 2004/17/EC and 2004/18/EC (the Public Procurement Directives),[49] require that public contracts be awarded according to the stringent re-

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[47] *See generally* Armin Bartosch, *The Relationship of Public Procurement and State Aid Surveillance–The Toughest Standard Applies?*, 39 COMMON MKT. L. REV. 551 (2002) (discussing the increasing interaction between the State aid ban and rules on public procurement). *See* Bovis, *supra* note 43 at 79-109 for a more recent account of the relationship between the two series of rules.

[48] Consolidated Version of the Treaty Establishing the European Community, Nov. 10, 1997, art. 87, 1997 O.J. (C340) 3.

[49] Directive 2004/17/EC of the European Parliament and of the Council, Coordinating the Procedures of Entities Operating in the Water, Energy, Transport and Postal Services Sectors, 2004 O.J. (L134) 1 (EC). Directive 2004/18/EC of the European Parliament and of the Council, On the Coordination of Procedures for the Award of Public Works Contracts, Public Supply Contracts and Public Service Contracts, 2004 O.J. (L134) 114 (EC).

quirements of publicity, transparency, mutual recognition, and non-discrimination. Compliance to these requirements is overseen by national jurisdictions which have been awarded extraordinary powers to that effect by the so-called "procedures" Directive.[50]

Second, a logical conclusion stems from the aforementioned discussion. Since both sets of rules pursue the same objectives, they need 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 be considered an undertaking—money transfers between public bodies or in favor of non-commercial entities are not encompassed by the rules on state aid authorities. On the other hand, public procurement rules are deemed to apply to the so-called "public markets" (*marches publics*), "where the state and its organs enter in pursuit of public interest" and not for profit maximization.[51] Hence, "contracting" in the sense that the public procurement directives are the state, regional, and local authorities as well as "bodies governed by public law." The latter's legal form (such as a public scheme or company) is irrelevant,[52] as long as three conditions are met: possess a legal personality, be financed or controlled by the state (or an emanation thereof), and have been "established for the specific purpose of meeting needs in the general interest, not having an industrial or commercial character."[53] The Court has made it clear that these are cumulative conditions.[54] Member States have been invited to enumerate, in Annex III of Directive 2004/18/EC, national "bodies" which fall in the above category.

However, this enumeration is not exhaustive and the European Court of Justice has been called upon on several occasions to interpret the three previously stipulated conditions. Unsurprisingly, the most con-

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[50] Council Directive 89/665/EEC 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, 1989 O.J. (L395) 33 (EEC). Now replaced by Directive 2007/66 of the European Parliament and of the Council, Amending Prior Council Directives With Regard to Improving the Effectiveness of Review Procedures Concerning the Award of Public Contracts, 2007 O.J. (L335) 31 (EC) (which should be transposed into national law before Dec. 20, 2009).

[51] *See* Bovis, *supra* note 43, at 82. See also two articles from the same author: Christopher Bovis, *Recent Case Law Relating to Public Procurement: a Beacon for the Integration of Public Markets*, 39 COMMON MKT. L. REV. 1025 (2002) (discussing applicability of procurement rules to various markets) and Christopher Bovis, *The Regulation of Public Procurement as a Key Element of European Economic Law*, 4 EUR. L.J. 220.

[52] Case C-360/96, Arnhem v. BFI Holding, 1998 E.C.R. I-6821.

[53] Directive 2004/18/EC, s*upra* note 49.

[54] Arnhem, 1998 E.C.R. I-6821, at I-6861. *See* Case C-44/96, Mannesmann Austria v. GesmbH, 1998 E.C.R. I-73, at para. 61.

troversial condition has been the one related to the opposition between activities in the pursuance of general interest and activities of an industrial or commercial character. Following the judgments of the Court in the *Mannesmann*,[55] the *BFI Holding*,[56] and the recently decided *Agora & Excelsior* cases,[57] two key conclusions can be drawn.

First, the fact that a particular activity serves the general interest does not in itself exclude the industrial or commercial character of that activity. In the words of the ECJ, 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."[58]

Second, in order to ascertain in which of the above categories an activity falls, the Court uses a set of criteria (*faisceau d'indices*) which may be summarized as follows (1) the absence of considerable competition in providing the same activity, (2) the existence of decisive state control over the said activity,[59] (3) the pursuance of the activity and the satisfaction of the relevant needs in a way different from what is offered in the market place, and (4) the absence of financial risk, are all factors which point towards the absence of industrial and commercial character.[60]

These criteria are very similar to the ones used by the ECJ in order to determine whether an entity should be viewed as an "undertaking."[61] Therefore, it would appear, to the extent that the two series of criteria are applied consistently, an entity which is not an undertaking will more often than not be considered to be a contracting entity. Hence, any given entity will be subject either to the competition and state aid rules or to the ones on public procurement but not both.[62] This viewpoint also finds support in the very text of the Utilities Procurement Directive, both

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[55] Mannesmann, 1998 E.C.R. I-73.

[56] Arnhem, 1998 E.C.R. I-6821.

[57] Joined Cases C-223/99 and C-260/99, Agora v. Ente Autonomo, 2001 E.C.R. I-3605.

[58] Agora, 2001 E.C.R. I-3605, at para. 32.

[59] Not the entity providing it, this is a distinct condition directly enumerated in the Directives. *See* Directives 2004/17, 2004/18, 89/665, and 2007/66, *supra* notes 49 and 50.

[60] *See* Christopher Bovis, *EC Public Procurement: Case Law and Regulation* (2006), Chapter 7. *See also* SUE ARROWSMITH, THE LAW OF PUBLIC AND UTILITIES PROCUREMENT, ch. 5 (1996). See also the second edition of that book, published in 2005.

[61] For these criteria, see *infra* Part V.C.2. *See* Hatzopoulos, *Health Law and Policy, supra* note 32, at 149-155, for more detail on the health sector. *See also* Bovis, *supra* note 43, at 84.

[62] ARROWSMITH, *supra* note 60, at 265.

in its previous version (Directive 93/38/EC Article 8.1)[63] and in its current version (Directive 2004/17/EC, Article 30) where it states 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 between state aids and public procurement has been transformed into a formal one in the European Court of Justice's judgment in *Altmark*[64] and the European Commission's "*Altmark* package." In *Altmark*, the ECJ made clear that subsidies given to an undertaking for the accomplishment of some service of general interest, may not constitute a state aid, provided four conditions are met,[65] cumulatively:

> First, the recipient undertaking must actually have public service obligations to discharge, and the obligations must be clearly defined. Second, the parameters on the basis of which the compensation is calculated must be established in advance in an objective and transparent manner. Third, the compensation cannot exceed what is necessary to cover all or part of the costs incurred in the discharge of the public service obligations, taking into account the relevant receipts and a reasonable profit. Finally, where the undertaking, which is to discharge public service obligations, in a specific case is not chosen pursuant to a public procurement procedure which would allow for the selection of the tenderer capable of providing those services at the least cost to the community, the level of compensation needed must be determined on the basis of an analysis of the costs, which a typical undertaking, well run and adequately provided with means of transport, would have incurred.[66]

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[63] Council Directive 93/98 Coordinating the Procurement Procedures of Entities Operating in the Water, Energy, Transport and Telecommunications Sectors, 1993 O.J. (L 199/84) (EC). Art. 8(1) of this Directive was interpreted by the Court in Case C-392/93, The Queen v. H.M. Treasury, *ex parte* British Telecomm. Plc., 1996 E.C.R. I-1613.

[64] Case C-280/00, Altmark v. Nahverkehrsgesellschaft Altmark, 2003 E.C.R. I-7747. *See, e.g.*, Massimo Merola & Caroline Medina, *De l'Arrêt Ferring à l'Arrêt Altmark: Continuité ou Revirement dans l'Approche du Financement des Services Publics*, CAHIERS DE DROIT EUR. 639 (2003).

[65] Altmark, 2003 E.C.R. I-7747, para. 87.

[66] *Id*., paras. 89-93 and Commission Decision 2005/842 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, art. 3, 2005 O.J. (L 312) 67, 71 [hereinafter Commission Decision 2005/842/EC].

From the very wording of the fourth condition, it follows that the default setting for the attribution and finance of some public service obligations is through public procurement. Only in an exceptional circumstance, which at present is not the case, should prices be determined according to hypothetical market conditions.

More significant than the wording is the substantive content of the fourth condition which suggests that the application of the procurement rules will be the very means used to avoid the applicability of the state aid rules. For one thing, it will be very difficult to prove what the costs of "a typical undertaking, well run and adequately provided with means of transport" would have been in a hypothetical market (when "well run" is well enough and what are "adequate" means of transport?). Most importantly, for most services of general interest, there is no market other than the one emerging under the influence 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.[67] The most reliable way to benefit from the Court's judgment in *Altmark* and to avoid the application of the rules on state aid would be to attribute public service contracts (and the related funding) following public tenders, these, in turn, would have to be organized according to the procurement procedures.[68]

Furthermore, the three first conditions of the *Altmark* test are also certain of being fulfilled by the award of public service contracts through public tenders—although they do not necessarily require such tenders. The award contract will fulfill the formal requirement of condition number one. The content of the tender documents will satisfy conditions two and three. [69]

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[67] See further, for the difficulties of these conditions Idot, *supra* note 46.

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

[69] It may be that the Court in *Altmark* got inspired from the draft proposal for a regulation of the EP and the Council on action by member states concerning public service requirements and the award of public service contracts in passenger transport by rail, road, and inland waterway, in 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 EP and the Council and is currently on the verge of being adopted on the basis of a substantially modified draft. *See* Communication from the Commission to the European Parliament, COM (2006) 805 final (Dec. 12, 2006).

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

First, Directive 2005/81/EC[70] modifies Directive 80/723/EEC [71] and requires any undertaking which "receives public service compensation in any form whatsoever in relation to such service and that carries on other activities" in order to proceed to the accounting separation of activities for which it receives compensation from the others.[72]

Second, and more importantly, Commission Decision 2005/842/CE,[73] 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" covers three categories of service providers (1) any service provider of small size (turnover of under € 100 million during the last two years) receiving a limited amount of compensation (€ 30 million annually), (2) transport serving up to a certain number of passengers, and (3) hospitals and social housing undertakings, without any limitation.[74] This text offers important information concerning the manner in which the Commission will apply the four *Altmark* criteria—particularly the one 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"[75] sets forth the Commission's position in respect to those subsidies which do not fall either under the *Altmark* judgment (and therefore evade being qualified as aid) or under the "*Altmark* Decision" (in which case it would constitute as aid) and need to be notified in order to obtain an individual declaration of compatibility.

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[70] Commission Directive 2005/81/EC 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, 2005 O.J. (L 312/47).

[71] Commission Directive 80/723 On the Transparency of Financial Relations between Member States and Public Undertakings, 1980 O.J. (L 195) 35 (EEC).

[72] Commission Directive 2005/81, *supra* note 70, art. 1.

[73] Commission Decision 2005/842/EC, *supra* note 66.

[74] *Id*.

[75] Community Framework for State Aid in the Form of Public Service Compensation, 2005 O.J. (C 297) 4 (EU) [hereinafter Community Framework]. In a different context, it would make sense to inquire what a "Community Framework" is and how this is different from a Communication, if at all.

The *Altmark* package was further augmented by two texts of (ultra) soft law, in the form of Commission Staff Working Documents, attached to the latest Commission Communication on "Services of General Interest, Including Social Services of General Interest."[76] Each of these Working Documents contains a list of frequently asked questions and answers thereto. The first Working Document answers questions concerning the application of public procurement rules to social services of general interest,[77] while the second and most extensive Working Document provides an interpretative tool for the *Altmark* Decision 2005/842/EC.[78] 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.[79]

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[76] Commission of the European Communities Communication 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 [hereinafter Commission Communication on Services of General Interest], *available at* http://ec.europa.eu/services_general_interest/docs/com_2007_0725_en.pdf.

[77] Commission Staff Working Document – Frequently Asked Questions Concerning the Application of Public Procurement Rules to Social Services of General Interest–Accompanying Communication on "Services of General Interest, including Social Services of General Interest: A New European Commitment," SEC (2007) 1514 final [hereinafter Commission Staff Working Document 1514], *available at* http://ec.europa.eu/services_general_interest/docs/sec_2007_1514_en.pdf.

[78] Commission Staff Working Document - Frequently Asked Questions in Relation with 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-Accompanying Document to the Communication on "Services of General Interest, including Social Services of General Interest: A New European Commitment," SEC (2007) 1516 final [hereinafter Commission Staff Working Document 1516], *available at* http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:52007SC1516:EN:HTML.

[79] While these lines were being proofread, the *Altmark* orthodoxy received an important blow from a case judgment by the Court of First Instance [CFI] on Feb. 12, 2008. *See* Case T-289/03, British United Provident Ass'n Ltd. v. Comm'n, 2008 O.J. (C 79) 25 [hereinafter BUPA]. In BUPA, 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 see a political judgment unlikely to reverse the stricter *Altmark* logic. *Id*.

In light of the above texts, there is no doubt that despite the other approaches followed previously by the Court[80] that the current "compensation" approach prevails when determining whether public funds dispensed for the accomplishment of general interest services constitute as aid. Within this approach, the rules on public procurement play a dual role. Externally, as a means of defining the scope of application of the state aid rules: where an entity charged with some mission of general interest qualifies as a contracting entity, it is unlikely to be an undertaking.[81] Therefore, it may receive public funds without being constrained by the rules on state aid. Internally, as the core condition for the circumvention of the state aid rules by virtue of Article 86(2) of the European Community Treaty, following the *Altmark* principles.[82]

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 (1) is it an undertaking or not? If it is itself a contracting entity then the answer is most likely to be negative; however, if the answer is positive, then (2) does the undertaking fall in any of the categories contemplated by the *Altmark* decision (small size, transport, and hospital), in which case the aid is deemed lawful, without notification being necessary? If the answer is negative, then (3) is the money received compensation for some public service in the meaning of the *Altmark* judgment? If the undertaking in question has not been chosen following a public tender procedure, the likely answer is negative and the monies received will constitute an aid; then (4) 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 greatly emphasized by both the Court and the Commission dur-

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[80] *See, e.g.*, Bovis, *supra* note 43, at 95-97 (discussing the three approaches under which the European judiciary and the Commission have examined the financing of public services: the *state aids approach*, the *compensation approach*, and the *quid pro quo* approach).

[81] *See* Directive 2004/18/EC, *supra* note 49, art. 1(9)(a), and discussion *supra* Part A.

[82] *See* discussion *supra* Part IV.B.

ing the past few years.[83] In fact, the relevant case law together with the *Altmark* judgments discussed earlier in the article constitutes the two main developments of economic law in the Court's case law these last years.

The European Court of Justice has handed down two series of judgments in this regard. 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. First, in *Commission v. France*, *Nord Pas de Calais*,[84] the Court held 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 Verlags GmbH and Telefonadress GmbH v. Telekom Austria AG*,[85] a case concerning a concession in the field of telecommunications, the ECJ found that the same principle also applies to concession contracts (and presumably any other type of contract which involves public funding and is not covered by the Procurement Directives). The public procurement directive has a specific scope of application limited to the traditional procurement pattern whereby the state/contracting entity purchases a given good or service and offers it to the public.[86] In recent years, however, alternate arrangements for public procurement have emerged, especially in the field of service whereby the contractor replaces the store in offering the service to the public directly, thereby getting his/her remuneration, for such concessions contracts are not covered by the procurement directives.[87] The Court held that, independent of any rule of secondary legislation, Articles 43 and 49 of the EC Treaty require *the principles of equal treatment, non-discrimination, and transparency* to be complied with under any circumstance.[88]

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[83] *See* Christopher Bovis, *Developing Public Procurement Regulation: Jurisprudence and its Influence on Law Making*, 43 COMMON MKT. L. REV. 461 (2006).

[84] Case C-225/98, Comm'n v. France, 2000 E.C.R. I-7445.

[85] Case C-324/98, Telaustria Verlags GmbH v. Telekom Austria AG, 2000 E.C.R. I-10745. Courts subsequently affirmed that concession contracts must also follow a non-discrimination policy in Case C-231/03, Consorzio Aziende Metano (Coname) v. Comune di Cingia de' Botti, 2005 E.C.R. I-7287; Case C-458/03, Parking Brixen GmbH v. Gemeinde Brixen and Stadtwerke Brixen AG, 2005 E.C.R. I-8585; and Case C-234/03, Contse SA v. Instituto Nacional de Gestión Sanitaria, 2005 E.C.R. I-9315.

[86] Telaustria Verlags, 2000 E.C.R. I-10745.

[87] *Id.*

[88] *See, e.g.*, Parking Brixen, 2005 E.C.R. I-8585, paras. 2, 48-49, 52, 72.

Picking up on the momentum created by these judgments, the EC Commission has come up with an interpretative Communication "on the community law applicable to contract awards not or not fully subject to the provisions of the public procurement directives" (the so called *de minimis* Communication).[89] This Communication covers contracts below the thresholds for the application of the Procurement Directives and contracts which are covered by the Directives but are only subject to the general publicity obligations—not the technical procurement rules.[90] 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.[91] The outcome of the process was the 2008 Interpretative Commission Communication.[92] The *de minimis* Communication basically explains the way in which the principles set out by the Court's jurisprudence should be put to work. The four principles (hereinafter the "procurement principles") pursued are: non-discrimination (based on nationality) and equal treatment (also in purely national situations), transparency, proportionality, and mutual recognition. According to the 2006 Communication, the obligations accruing for contracting entities under the general Treaty rules are proportionate to the interest that the contract at stake presents for parties in other Member States. Four aspects of the award procedure are taken up by the Commission: advertising prior to the tender, content of the tender documents, publicity of the award decision, and judicial protection.

The ECJ 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 found in the Court's judgment in *Massimiliano Placanica e.a.*, a case concerning bet collection in Italy.[93] According to the Italian legislation, this activity required a government license from which undertakings

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[89] Commission Interpretative Communication on the Community Law Applicable to Contract Awards Not or Not Fully Subject to the Provisions of the Public Procurement Directives, 2006 O.J. (C 179) 2 [hereinafter Commission Interpretative Communication].

[90] For list of services, see Directive 2004/17/EC, *supra* note 49, Annex XVII B, and Directive 2004/18/EC, s*upra* note 49, Annex II B.

[91] *See* Commission of the European Communities Communication on Public-Private Partnerships and Community Law on Public Procurement and Concessions, COM (2005) 569 final.

[92] Commission of the European Communities Interpretative Communication on the Application of Community Law on Public Procurement and Concessions to Institutionalised Public-Private Partnerships (IPPP), C (2007) 6661.

[93] Joined Cases C-338, C-359 & C-360/04, Procuratore della Republicca v. Placanica, 2007 E.C.R. I-1891.

quoted in the stock market (mostly non-Italian) were altogether excluded. The Court did not restrict itself to finding that such blanket exclusion was disproportionate to the objective of protecting consumers. It further stated that whenever operators have been unlawfully excluded from the award of licenses (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 licenses or the award by *public tender* of an adequate number of new licenses."[94] This reflects an idea which is being implemented in the regulated industries (such as telecommunications and energy) and which had been put forward by the Commission (but never invoked) in a more general scale, concerning access to essential facilities:[95] whenever some scarce resource is to be distributed between competitors, the way to do so is through public tendering procedures.

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

Therefore, according to the latest case law of the ECJ, the basic principles governing public procurement become a key regulatory instrument for the regulation of the internal market.

## V. APPLYING THE EC RULES TO NATIONAL HEALTH CARE

Against this background, the question arises as to how and to what extent the rules—or indeed the principles—on public procurement and state aid affect or should affect the provision of health care in the Member States.[96] Since the rules on state aid and public procurement are

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[94] *Id.* at para. 63 (emphasis added).

[95] Organisation for Economic Co-Operation and Development, The Essential Facilities Concept, OCDE/GD(96)113, at 102 (1996), *available at* http://www.olis.oecd.org/olis/1996doc.nsf/LinkTo/OCDE-GD(96)113 (last visited Sept. 24, 2008).

[96] For the first (and latest) official position on this issue, see Commission Communication on Services of General Interest, *supra* note 76. This Communication comes in set with two "working

so closely related and their application rests on the same set of criteria[97] the analysis that follows examines each individual criteria 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. However, this general assertion is fraught with ambiguities.

Assuming that universal coverage of the population is an absolute aim (and hence the personal scope of the system is inelastic), there are at least three variables in defining the scope of "general interest" in the field of health care. The first variable deals with the kinds of treatments (and pharmaceuticals) provided by the system which varies from one state to another; the availability of treatments is influenced by religious, moral, and scientific perceptions. Cosmetic surgery, sex modification, pain treatment, and abortions are just some examples of where divergences exist amongst various Member States. The second variable, which pertains to the quality of medical treatments, may vary due to: the qualification of health professionals; the number of health professionals; the medical infrastructure of the hospitals (number and quality); waiting time for having access to the system; and waiting time for receiving any given treatment. The third variable concerns the quality of non-medical services, such as accommodation, catering, and cleaning.

In most Member States, the level of health care that should be provided is described in one or more legislative acts. In some states, a general provision securing a high level of health care to the population can also be found in the Constitution.[98]

However, these norms, even when they go beyond mere principles, very rarely provide a detailed description of the aforementioned variables and subsequently fail to define the precise scope of general interest in health care. On the other end, the very detailed and complex

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documents," Commission Staff Working Document 1514, *supra* note 77 and Commission Staff Working Document 1516, *supra* note 78.

97 *See supra* Part IV.A–B.

98 *See supra* n. 2.

rules concerning the calculation of various treatment units and the funding of various parts of hospital budgets do not stand for the definition of services of general interest in health care.

Therefore, it would seem that the application of EC law would require the introduction of the concept of "service of general interest" or "public service" and a precise definition of its content in the field of health care. 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 manner more detailed than that found in the general constitution or 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? Second, the *Altmark* ruling entails a logical shift—while the national logic is one of defining the scope of a health care *system*, the European Community logic is to define a *set of* health care *services* of general interest. Third, and directly related to 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."[99] This view finds support in the case law of the ECJ.[100] However, 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, as patients would then be entitled to receive treatment in other Member States at the charge of their home authorities, under the "free movement of patients" jurisprudence. Fourth, a more radical idea may be put forward:[101] 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. Then only would the funds be performing some task of general economic interest. However, in the view of both the preceding paragraphs and the "*Altmark* decision" it exempts

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[99] Commission Decision 2005/842, *supra* note 66, at para. 7, and Community Framework, *supra* note 75, at para. 9.

[100] *See, e.g.*, Case C-76/97, *Tögel v. Niederösterreischische Gebietskrankenkasse*, 1998 E.C.R. I-5357 and Case C-119/06, Comm'n v. Italy, 2008 O.J. (C 22) 7 (dismissed with costs against Commission).

[101] *See, e.g.*, Géraldine Chavrier, *Etablissement public de santé, logique économique et droit de la concurrence*, REVUE DU DROIT DE LA SÉCURITÉ SOCIALE, Mar.-Apr. 2006, at 274-287 (Fr.).

hospitals from the application of the state aid rules. Thus, 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 remarks should be made.

### 1. DISTINGUISHING CAPITAL COSTS FROM EXPLOITATION COSTS

In most Member States there is a rather clear distinction between (1) capital investment and infrastructure and (2) exploitation.[102] Two points should be made in this respect.

First, the direct financing of infrastructure by the public purse may affect competition both at the hospital level (between public/private and between the hospitals of different Member States) and at insurance funds level. The Belgian experience is instructive in this respect. In Belgium, hospital infrastructure is financed at 40 percent by the Federal Ministry of Health, while the remaining 60 percent is funded by the linguistic Communities. When Belgian hospitals conclude contracts with Dutch health insurers, they charge the same tariffs as they do to the Belgian health insurance system. This means that investment cost for hospitals is only charged for 40 percent. Some Dutch hospitals do perceive this as a distortion of competition and a Dutch organization of hospitals voiced that they do consider this as impermissible state aid in favor of the Belgian hospitals.[103] It is difficult, however, to see how such a distortion could be remedied. The 40:60 funding, linked to the federal structure of the state and embodying important political choices, may not be put directly into question by the rules on state 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.

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

[103] Irene Glinos, Nick Boffin & Rita Baeten, Cross-Border Care in Belgian Hospitals: An Analysis of Belgian, Dutch and English Stakeholder Perspectives 66 (2005), *available at* http://www.ose.be/files/health/BelgianCaseStudy_ForPrint.pdf.

Second, though infrastructures and other fixed costs have traditionally been financed directly by the public purse, in recent years some states have tried to attract private investment. The Private Funding Initiative (PFI) in the UK has set the pace and other countries have followed suit.[104] The emergence of new contractual forms, such as PPPs and concessions offer further means of bringing in private funds. However, it is important to note that the choice of private investors who will participate in the capital of public hospitals (similar to other public infrastructures) may only be made according to the "public procurement principles."[105]

### 2. CALCULATING THE COST OF PUBLIC SERVICE

Hospitals' budgets have very complicated structures and vary from one State to another. A shared trait is that next to capital investment cost they distinguish between fixed costs (such as maintenance, heating, and personnel) and variable costs (which are linked directly to the volume of their activity). The way to calculate this latter set 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 approaches have emerged: advance payments of prospective budgets based on average costs of hospitals of the same category; calculate the average costs on the basis of DRG or equivalent measuring unit,[106] only occasionally completed or adjusted by the application of fee for service or length of stay criteria; make it possible for efficient hospitals to keep any surplus. Not only do these measures force the hospitals to adopt a sounder management of financial resources, it also dramatically increases transparency. By the same token, the *Altmark* requirement of calculating the precise cost of public service is likely to be satisfied.

The principles of transparency and cost calculation are also upheld by the fact that in the majority of Member States, practitioners are mainly self-employed and enter into contracts with hospitals or funds. A

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[104] *See* Irina Nikolic & Harald Maikisch, Public-Private Partnerships and Collaboration in the Health Sector: An Overview with Case Studies from Recent European Experience (2006), *available at* http://siteresources.worldbank.org/INTECAREGTOPHEANUT/Resources/HNPDiscussionSeriesPPPPaper.pdf.

[105] *See supra* Part IV.C.

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

prevailing practice is the way that physicians' fees are fixed. For example, it would appear that a system of public tendering like the Italian one would be preferable to the Belgian one, where fees are fixed under the auspices of the public fund[107] and may or may not be adhered to by each individual physician.[108] A different, but related issue is the price public hospitals should charge practitioners for the use of the hospital infrastructure in order to offer "for fee" health care services outside the health system.

Another issue that must be considered in assessing transparency is the method of calculating the cost of public service and how it 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. The mediation of public money or of money paid by a central fund through local authorities (e.g., Hungary and Italy), may result in political choices altering knowledgeable economic calculations. As a result, the calculation of the cost of public service may be flawed, thereby making the application of the public procurement and/or state aid laws more likely. Calculating the cost of public service is directly linked to the manner by which it is financed.

### 3. FUNDING THE COST OF SERVICES OF GENERAL INTEREST

According to the Commission's *Altmark* decision, state aid given to hospitals for the accomplishment of public service obligations entrusted to them is exempt from notification and is automatically legal, irrespective of the amount.[109] However, aid awarded to hospitals must be strictly calculated in order to meet the economic needs of public service. Several questions arise in this respect.

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

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[107] The "Institut National d'Assurance Maladie-Invalidité," known as INAMI.

[108] The Court is not particularly keen in price-fixing by professional associations and other bodies. *See* Joined Cases C-94 & C-202/04, Cipolla v. Fazari, 2006 E.C.R. I-11421. See also, at the national level, a settlement reached before the Irish Competition Authority on May 25, 2007, whereby the Irish Medical Organisation, an association of General Practitioners in Ireland, has undertaken not to take action in relation to prices in respect of several of their activities. For settlement report and brief commentary, see Orla Lynskey, *The Irish Competition Authority Settles Price-fixing Proceedings in the Health Insurance Sector (Irish Medical Organisation - IMO)*, e-Competitions, May 25, 2007, no. 14004, available at http://www.concurrences.com/abstract_bulletin_web.php3?id_article=13967 (last visited Oct. 15, 2008). (On file with author).

[109] Commission Directive 2005/81, *supra* note 70, at art. 1.

ascertain such failure—it may be that some system of monitoring should be set up as a consequence of the *Altmark* requirements.[110] Second, such a monitoring system appears to be required in order to control overcompensation. Third, under the Decision, overcompensation is explicitly ruled out and must be paid back, subject to a margin of 10 percent which may be carried forward to the next year.[111] Therefore, the system of efficient hospitals "keeping the surplus" of their annual budget introduced in some states as an incitement for efficient management[112] should be revised. 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.

The above applies to monies given to hospitals directly by the state budget (e.g., England),[113] or by public insurance funds or funds where membership is compulsory (e.g., Italy, Hungary, Belgium, and Greece).[114] It is unclear whether the same principles apply to a system like the Dutch system, 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 in this latter case.

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[110] It would seem that Commission Decision 2005/842/EC does require some monitoring, especially to overlook overcompensation. *See* Commission Decision 2005/842/EC, *supra* note 66, at L 312/71.

[111] *Id*. at para 13.

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

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

[114] For an example where state aid in the form of payment facilities was given by the Belgian pension fund ONSS (which is the INAMI equivalent in the field of pensions) to a private undertaking, see Case C-256/97, Déménagements-Manutention Transp. SA (DMT), 1999 E.C.R. I-3913. *See also* Case C-75/97, Belgium v. Comm'n, 1999 E.C.R. I-3671.

### C. WHO IS A CONTRACTING ENTITY – WHO IS AN UNDERTAKING?

In the analysis above, it has been postulated 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 criteria for determining when an entity qualifies as an undertaking are as broad as "the exercise of an economic activity."[115] On the other hand, a contracting entity is one which "does not pursue an activity of economic or commercial nature."[116] Furthermore, one of the fundamental principles of the market economy is that operators may contract with whomever they wish:[117] any given entity may not be subject simultaneously to free competition and to the restrictive and time consuming rules on public procurement.[118] This, however, is not necessarily true in a hybrid economic sector, such as the provision of health care. Possibly more controversial than the technical issues mentioned above is the more general question of whether health care provision should be subject to the procurement rules at all. In this respect (1) the lack of flexibility of the procurement rules, especially with regards to the role of non-profit social organizations, (2) the transformation of partnership relationships into competitive relationships, (3) the restriction of cooperation between local authorities, resulting from the restrictive concept of "in-house contracting" followed by the European Community, (4) the negative effect on establishing long-term trust relationships with suppliers and other partners, (5) the possible disruption of the continuity of public service, (6) increased transaction costs, and (7) delay, are just some of the arguments put forward against the general application of public procurement rules in the core of health provision.[119] Most of these concerns are being dealt with—although not really answered—by the Commission in its most recent Communication

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[115] *See* OKEOGHENE ODUDU, THE BOUNDARIES OF EC COMPETITION LAW: THE SCOPE OF ARTICLE 81, at 24-25 (2006).

[116] *See* ARROWSMITH, *supra* note 60 and BOVIS, *supra* note 60.

[117] 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 U.S. 300, 304-308 (1919).

[118] *See supra* Part IV.B.

[119] *See, e.g.*, Social Services of General Interest: Feedback Report to the 2006 Questionnaire of the Social Protection Committee, at 10-12, *available at* http://ec.europa.eu/employment_social/social_protection/docs/feedback_report_en.pdf. *See also* Mathias Maucher, Observatory for the Development of Social Services in Europe at the Institute for Social Work and Social Education (ISS), *Analysis of the Replies of All European Union Member States' Governments to the Questionnaire of the Social Protection Committee Preparing the Communication on Social and Health Services of General Interest* (2005), http://www.soziale-dienste-in-europa.de/Anlage25573/auswertung-antworten-ms-mitteilung-sgdai-ed.pdf.

on Services of General Interest and the accompanying documents.[120] In these texts, the Commission confirms its attachment to the application of the public procurement rules and principles.

### 1. CONTRACTING ENTITIES: SOME CERTAINTY?

In Annex III of Directive 2004/18, Member States have enumerated, in a non-exhaustive manner, the entities which they deem subject to the procurement rules. With a snapshot, it becomes clear that Member States have no shared views about the role the various entities play in their respective health care systems.

### 2. 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.[121] Conversely, doctors who are public employees (as is the case for the vast majority in Hungary) are not considered to be undertakings.

The status of insurance funds is more complicated. A very broad distinction may be drawn between funds where membership is compulsory and those offering complementary coverage; the former would not qualify as undertakings while the latter would. The reason is that in the former, the state's intervention, in order to secure the objective of "universal minimum cover," may be such that their commercial freedom is jeopardized. In contrast, regulation of most markets for complementary and supplementary coverage tends to focus on *ex post* scrutiny of financial returns on business to ensure that insurers remain solvent.[122] However, this differentiation is simplistic and may be misleading. Private funds offering "complementary" coverage account for an increasing portion of the market (10 to 20 percent of total health expenditure in the EU) and tend to be increasingly regulated by Member States, in a way that their qualification as "undertakings" may be put into question.

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[120] *See* Commission Communication on Services of General Interest, *supra* note 76, and Commission Staff Working Document 1514, *supra* note 77.

[121] Joined Cases C-180 & C-184/98, Pavlov v. Stichting Pensioenfonds Medische Specialisten, 2000 E.C.R. I-6451.

[122] For this excerpt and for the critique which follows, see Sarah Thomson & Elias Mossialos, *Regulating Private Health Insurance in the European Union: The Implications of Single Market Legislation and Competition Policy*, 29 J. EUR. INTEGRATION 89, 93-94 (2007).

There is no hard and fast rule for determining whether an insurance fund qualifies as an undertaking. Instead the Court refers to a set of criteria (*faisceau d'indices*). From a relatively long series of judgments,[123] it follows that elements which would point to a non-market entity, include[124] (1) the social objective pursued, (2) the compulsory nature of the scheme, (3) contributions paid being related to the income of the insured person, not to the nature of the risk covered, (4) benefits accruing to insured persons not being directly linked to contributions paid by them, (5) benefits and contributions being determined under the control or the supervision of the state, (6) strong overall state control, (7) the fact that the funds collected are not capitalized and/or invested, but merely redistributed among participants in the scheme, (8) cross-subsidization between different schemes, and (9) the non-existence of competitive schemes offered by private operators.[125]

Based on the criteria set forth above, and in particular, the European Court of Justice's judgment in *Federación Española de Empresas de Tecnología Sanitaria (FENIN) v. Commission*,[126] it would appear that public hospitals securing adequate treatment to individual patients, typically free of charge, do not qualify as undertakings. This logic however,

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[123] *See* Case C-244/94, Fédération Française des Sociétés d'Assurance v. Ministère de l'Agriculture et de la Pêche, 1995 E.C.R. I-4013; Case C-70/95, Sodemare SA v. Regione Lombardia, 1997 E.C.R. I-3395; Case C-67/96, Albany Int'l BV v. Stichting Bedrijfspensioenfonds Textielindustrie, 1999 E.C.R. I-5751; Joined Cases C-115, C-116 & C-117/97, Brentjens' Handelsonderneming BV v. Stichting Bedrijfspensioenfonds voor de Handel in Bouwmaterialen, 1999 E.C.R. I-6025; Case C-219/97, Maatschappij Drijvende Bokken BV v. Stichting Pensioenfonds voor de Vervoer- en Havenbedrijven, 1999 E.C.R. I-6121; Case C-218/00, Cisal di Battistello Venanzio & C. Sas v. Istituto nazionale per l'assicurazione contro gli infortuni sul lavoro (INAIL), 2002 E.C.R. I-691; Case T-319/99, Federación Nacional de Empresas de Instrumentación Científica, Médica, Técnica y Dental (FENIN) v. Comm'n, 2003 E.C.R. II-357, *aff'd sub nom.* Case C-205/03 P, Federación Española de Empresas de Tecnología Sanitaria (FENIN) v. Comm'n, 2006 E.C.R. I-6295; Case C-355/00, Freskot AE v. Elliniko Dimosio, 2003 E.C.R. I-5263; and Joined Cases C-264, C-306, C-354 & C-355/01, AOK Bundesverband v. Ichthyol-Gesellschaft Cordes, 2004 E.C.R. I-2493. *See also* Laurence Idot, *Droit Social et Droit de la Concurrence: Confrontation ou Cohabitation? (À propos de Quelques Développements Récents)*, 9:11 EUROPE 4, 4-8, (1999).

[124] Note that these elements are broadly the same—but from the reverse side—as the ones used to identify contracting entities. *See supra* n. 61 and discussion *supra* Part IV.A.

[125] For a more detailed analysis of those criteria, see Hatzopoulos, *Health Law and Policy*, *supra* note 32. *See also* Francis Kessler, *Droit de la Concurrence et Régimes de Protection Sociale: un Bilan Provisoire*, *in* 1 SERVICE PUBLIC ET COMMUNAUTE EUROPEENNE: ENTRE L'INTERET GENERAL ET LE MARCHE 421, 430 (Robert Kovar & Denys Simon eds., 1998).

[126] Case T-319/99, Federación Nacional de Empresas de Instrumentación Científica, Médica, Técnica y Dental (FENIN) v. Comm'n, 2003 E.C.R. II-357, para. 37, *aff'd sub nom.* Case C-205/03 P, Federación Española de Empresas de Tecnología Sanitaria (FENIN) v. Comm'n, 2006 E.C.R. I-6295.

is being put into question by at least two developments. First, in the *Altmark* Decision, the Commission admits that money given to hospitals (irrespective of ownership) for fulfilling their public service obligations although justified, qualifies as aid.[127] 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; thus, it has considered them to be undertakings subject to the merger control.[128]

Therefore, it is difficult to foresee when a public hospital will be held to constitute an undertaking. It would appear that criteria such as: an independent board of directors, relative flexibility in the execution of the budget, contractual freedom, and a relatively developed side activity of a commercial nature is likely to make a public hospital qualify as an undertaking.[129] Consequently, hospitals having the legal form of a trust, such as hospitals in England and Italy, are likely to qualify as undertakings.

### 3. UNDERTAKINGS SUBJECT TO THE PROCUREMENT RULES?

It becomes apparent that it is very difficult to determine which entities in the health care field qualify as contracting entities, and entities which a few years ago were considered to be completely evading market rules are being treated increasingly as undertakings at both the EU and the national levels. In addition, these imprecise categories often overlap. A number of 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 guidelines set by the European Court of Justice. At the same time, most public hospitals do currently follow some procurement rules,[130] at least for purchasing goods (this is seen in England through the Purchasing and Supply Au-

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[127] Commission Decision 2005/842/EC, *supra* note 66.

[128] Helmut Bergmann & Frank Röhling, *The German Federal Cartel Office Vetoes A Merger of Two Public Hospitals (Greifswald University Hospital/Wolgast Hospital)*, *in* E-COMPETITIONS: EU COMPETITION LAWS E-BULLETIN, no. 12733 (2006). (On file with author).

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

[130] Greece has had infringement procedure initiated against it by the Commission for the technical specifications used in several tendering documents for the supply of medical devices. *See* Public Procurement: Infringement Procedures against Greece, Spain, and Portugal, IP/06/887 (June 29, 2006), *available at* http://europa.eu/rapid/pressReleasesAction.do?reference=IP/06/887&format=PDF&aged=1&language=EN&guiLanguage=en

thority [PASA], Greece, and Hungary). In Belgium, even private hospitals are subject to public procurement rules (at least for construction and heavy equipment) since they receive 60 percent of their capital investment budget from the Communities. At the same time, private hospitals and probably many public hospitals would qualify as undertakings. This is not a satisfying situation for the reasons explained in previous sections of this article.

Problems have also arisen following the recent "decentralization" of the application of European Community competition law introduced by Regulation (EC) 1/2003,[131] because it may result in very divergent solutions, especially those concerning borderline hospitals. In this respect, Decision 2005/842/EC (the *Altmark* decision) is a positive step, since it clears hospitals, irrespective of their qualification as undertakings, from the application of the state aid rules. It may be that a similar "block exemption" could also clarify the position of hospitals under Article 81 of the European Community. However, no advance clearance from the application of Article 82 may be given and the invocation of abuses against hospitals is a likely outcome. A possible remedy to this problem could lie in adopting a system in the health care field like the Utilities Procurement Directive (2004/17/EC) which would: require Member States to dress a complete list of all the entities considered as contracting entities (thus evading their being qualified as undertakings) and foresee a mechanism for the regular revision of this list, similar to Article 30 of the Directive, accounting for market developments and the introduction of competition.

### D. WHAT KIND OF AWARD PROCEDURES SHOULD BE FOLLOWED?

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

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[131] Council Regulation 1/2003 on the Implementation of the Rules on Competition Laid Down in Articles 81 and 82 of the Treaty, 2003 O.J. (L 1) 1 (EC).

### 1. NO CONTRACTUAL RELATIONSHIP

In some health care systems, the public authority responsible for delivering care set up and run their own treatment facilities in the form of treatment centers, small hospitals, or clinics. This is exemplified by the Local Health Authorities (ASLs) in Italy, the Primary Care Trusts (PCTs) in England, and by some funds in Greece. The ECJ 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, these are considered an "in-house provision" of services.[132] In-house service is any service provision offered between bodies with no separate legal personality. In the presence of distinct legal entities, in-house provisions only exist where two conditions are fulfilled in a cumulative manner: first, the procuring entity should exercise over the supplying entity "a control which is similar to that which it exercises over its own departments," and second, the supplying entity should carry out "the essential part of its activities" with the procuring entity.[133] While the second condition will rarely create a dilemma, hospitals created by public authorities or funds the first condition may prove problematic and counter productive in the future.

In a highly contested judgment in *Teckal*,[134] the ECJ held that private participation in the shareholding of a public company, even at a rate of 0.02 percent, may disturb the "similar control" of the local authority which controls the remaining 99.98 percent, unless such authority holds special privileges by virtue of the company's constitution. This may discourage public hospitals from seeking private investors or prevent investors from giving money to entities in which public authorities have privileges.[135] Both in England[136] and in Italy private funding initia-

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[132] *See* ARROWSMITH, *supra* note 60, para. 6.195-6.201. *See also* Marco Giorello, *Gestions in house, entreprises publiques et marchés publics: la Cour de justice au croisement des chemins du marché intérieur et des services d'intérêt économique général*, Revue du Droit de l'Union Européenne, 1/2006, 23-50.

[133] Parking Brixen, 2005 E.C.R. I-8585.

[134] Case C-107/98, Teckal Srl v. Comune di Viano, 1999 E.C.R. I-8121.

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

[136] *See* Nikolic & Maikisch, *supra* note 104, at 3.

tives for public hospitals are underway. Accordingly, in-house provisions will become increasingly unlikely. However, if the relationship is found to be "in-house" then no award procedure is necessary. No award is necessary either in the Hungarian and 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 entity has legal consequences only when the entities concerned purchase extra capacity outside their own "production."

### 2. CLOSED AWARDS

In some cases, Member States may wish to confer an exclusive or special right to one or several undertakings. Instituting such rights is not forbidden by the EC Treaty rules, particularly if such rights are linked to the provisions of services of general interest. This link may be direct (i.e., the service over which a special right is conferred is itself a service of general interest) or indirect (i.e., the service over which a special right is conferred is used to finance a contiguous service of general interest).[137] The Procurement Directives are not applicable to the award of such contracts,[138] but the general Treaty rules are. This means that, as the law presently stands, if new rights are to be awarded it should be done according to the "procurement principles."

### 3. OPEN AWARDS

On the opposite end, on many occasions, Member States award contracts not on the basis of a competitive tender but upon the fulfillment of several requirements stipulated in advance. In the field of health care, this practice is quite widespread. In many Member States, all physicians and/or all hospitals that fulfill several criteria may, under certain conditions, be contracted-in in the public health care system. This is true for physicians in Belgium, Hungary, Greece, the UK, and (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

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[137] *See* Case C-320/91, Criminal Proceedings against Paul Corbeau, 1993 E.C.R. I-2533; Case C-393/92, Mun'ty of Almelo v. Energiebedrijf Ijsselmij NV, 1994 E.C.R. I-1477; and Case C-475/99, Firma Ambulanz Glöckner v. Landkreis Südwestpfalz, 2002 E.C.R. I-8089 [hereinafter Glöckner].

[138] Directive 2004/18/EC, *supra* note 49, art. 18.

the conditions set in advance should be awarded a contract. Hence, the case law of the ECJ on the delivery of authorizations becomes relevant: the conditions for their delivery should be objective, transparent, non-discriminatory, and known in advance, while the procedure should take a reasonable time and be subject to judicial review.[139]

### 4. COMPETITIVE AWARDS

Finally, there are cases where a proper competitive tender is to be held. This is what should happen in Italy, the UK, Hungary, and Greece, when the relevant public authorities or Trusts need to contract-in hospitals and doctors (that is, 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. Health and social services are enumerated in Annex II, B of the Directive and are only subject to a partial application of its rules. The only Directive provisions which are applicable to the Annex II, B services are Article 23, on the technical specifications to be used in the tender documents and Article 35(4) on the publication of an award notice.[140] 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, equal treatment, transparency, proportionality, and mutual recognition. Therefore, the freedom left by the EC legislature in favor of entities operating in the health sector is seriously circumscribed by the recent case law of the ECJ. As explained above, this requires adequate publicity, extended mutual recognition, and most importantly, does not allow for clauses which would exclude directly or indirectly, operators from other Member States. The Commission's "Framework" Communication of the *Altmark* package, clarifies the above requirements, and further restricts the freedom of action of the contracting entities.

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[139] *See, e.g.*, Smits & Peerbooms, 2001 E.C.R. I-5473, Vanbraekel, 2001 E.C.R. I-5363, and accompanying text.

[140] Directive 2004/18/EC, *supra* note 49, art. 21. Mixed contracts, which involve the provision of both healthcare and other Annex II A services, should be awarded on the basis of the contract having the most important value. *Id*. art. 22. *See also* the Court's judgment in Glöckner, 2002 E.C.R. I-8089.

## VI. CONCLUSION

National health care systems embody the principle of solidarity and are aimed at ensuring universal coverage. In the EU, there are as many national systems as there are Member States. Although it is conceptually possible to distinguish the organization and provision of healthcare itself from the way individuals are financially assisted into the health care system, the two are intertwined, to a varying extent in European health care systems. Even in Member States where healthcare provision itself relies to a great extent upon private actors, universal coverage may not be assured without public funding.

The existence of public funding, however, does not preclude the application of the European Community Treaty rules. This, in turn, means that the injection of public money in fields where market forces are operational may not operate in an arbitrary way, but need to be channeled according to the EC Treaty and secondary European Community legislation: European Community rules on state aid and/or on public procurement become directly relevant. As a result, rules which are designed to regulate different situations and which, according to the recent case law of the ECJ, are connected through 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, the author put forward the idea that "entities caught by the rules on competition should be unequivocally exempted from observance of the rules on public procurement, while some guidelines should be drawn in order to avoid a rigid and counterproductive application of the rules on state aids on the organization and functioning of national health care systems."[141] 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, very rarely fulfilled. Further action may be required by the Commission, in the form of a block exemption regulation from Article 81 of the European Community Treaty for health care providers. Member States could themselves ease the application of the

[141] Hatzopoulos, *Health Law and Policy*, *supra* note 32, at 168.

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 this were to come into fruition, the legal situation would still be complicated, reflecting the material differences of the national health care systems.

How deeply the European Community 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 on both the regulatory technique used and on the positions adopted by the various actors.

In regards to regulatory techniques, in policy fields where hard law has a stronghold,[142] softer means of regulation could seem inappropriate. This view, however, should not overlook two factors. First, that the Commission itself has regularly relied upon soft law in the field of state aids and, recently, also in the field of public procurement (see e.g., the *de minimis* Communication on procurement).[143] Second, under pressure from technological developments, 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 converge model through some kind of soft cooperation, "in particular initiatives aiming at the establishment of guidelines and indicators, the organization of exchange of best practice, and the preparation of the necessary elements for periodic monitoring and evaluation."[144] The fact that the above quotation is directly taken from the Lisbon Treaty provision dealing with "Public Health" clearly indicates that this is a road which will be taken.

From the perspective of the actors involved, it must be observed that the process has been led by private litigators supported by the ECJ. The Commission, on other hand, has been notably absent. This pattern is likely to continue in the foreseeable future. Even if the Commission decided to assume a more active stance, it could be "silenced" by Member States and their parliaments. Indeed, Article 192(7) of the Treaty on the Functioning of the European Union as modified by the Lisbon Treaty provides that "Union action in the field of public health shall fully respect the responsibilities of the Member States for the definition of their health policy and for the organization and delivery of health services and

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[142] It is reminded that state aid is run on a daily basis and public procurement is regularly monitored by the Commission. *See supra* notes 77, 82, 98.

[143] Commission Interpretative Communication, *supra* note 89.

[144] Treaty of Lisbon, *supra* note 20, at C 306/83, art. 127(c).

medical care, and the allocation of resources assigned to them."[145] 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"[146] (supposing that the Lisbon Treaty will come into force) the Commission's initiatives are subject to strong scrutiny.

The use of soft law and coordination, combined with the absence of strong steering from the Commission, makes the impact of the EU rules on national health care systems very difficult to foresee. This impact is felt not only by the everyday running of the various health care systems of the Member States, but may also affect the very conception and general outlook of the systems themselves. It is not certain whether this is to be seen as an intended "spill-over" or as an unintended "collateral damage."

[145] *Id.* at C 306/84, art. 127(e).
[146] *Id*. at C 306/148-50.