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Financing Health Care in EU Law: Do the European State Aid Rules Write Out an Effective Prescription for Integrating Competition Law with Health Care?

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Many Member States have taken measures in order to finance their health care systems. However, it cannot be ruled that these measure run counter the European state aid rules, which could have adverse effects on health care. Therefore, the central question of the present paper is whether the ECJ's and CFI's case law and the measures taken by the Commission accommodate health care concerns in the application of the Articles 87-89 EC (Articles 107-109 TFEU). In this context the health care competences of the Member States are of great interest, because by balancing the health care and competition concerns the Community institutions could develop an approach that respects these competences. This article starts by exploring which health care concerns should play a role in applying the Community state aid rules. It will be argued that universal coverage is an important issue in the EU law approach towards health care. Hence, it will be examined to what extent concerns of universal coverage play a role in the application of the European State aid rules. Firstly, the concept of undertaking, which is the 'gate' to the state aid rules, will be explored. Subsequently, attention will be paid to Articles 87-89 EC.

1. INTRODUCTION

Article 152(5) of the EC Treaty (hereafter EC) provides that the organisation and delivery of health care is considered to be the responsibility of the Member States. In the Treaty of Lisbon this point of departure is reinforced because it is stressed that the responsibilities of the Member States include 'the management of health services and medical care and the allocation of the resources assigned to them'.¹ However, the policy measures taken by the Member States in the field of health care must comply with the basic Treaty provisions on competition law. Member States may still intervene in health care markets in order to guarantee access to health care for all. Financial instruments such as subsidies play a significant role in this respect. Here the EC state aid rules, laid down in Articles 87-89 EC, come into play.²

Article 87(1) EC prohibits Member States from distorting competition on the Common Market by giving state aid to undertakings. So, the fair chance exists that national

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¹ See the new wording of para 7 of the Article 168 Treaty on the Functioning of the EU. Moreover, this paragraph states that not only the Member States competences for 'the organisation and delivery of health services and medical care', but also 'the definition of their health policy' must be respected.

² The Treaty of Lisbon has renamed the EC treaty the Treaty on the Functioning of the European Union. The state aid rules are contained in Articles 107-109 of this treaty. As so far all important case law has been based on the old numbers of the EC Treaty, this contribution refers to these provisions.

measures financing health care activities may come under fire from the Community regime on state aid. Hence, the question arises whether this regime interferes with the Member States' competence to organise their health care systems. It goes without saying that the answer to this question largely depends on the case law of the Community courts (ECJ and CFI) and the (policy) measures taken by the Commission. Consequently, it should be examined whether these Community institutions integrate health care objectives into the application of the state aid rules. Are these non-competition goals relevant for European state aid law, which forms an integral part of the competition system of the EU?

The central question of the present paper is, therefore, whether the ECJ's and CFI's case law and the measures taken by the Commission accommodate health care concerns in the application of the Articles 87-89 EC. In this context the health care competences of the Member States are of great interest, because by balancing the health care and competition concerns the Community institutions could develop an approach that respects these competences.

This article starts by exploring which health care concerns should play a role in applying the Community state aid rules. Subsequently, the application of the state aid rules will be explored. This article ends by drawing some conclusions.

2. HEALTH CARE CONCERNS IN THE EU: THE VALUE OF UNIVERSAL COVERAGE

In the EU health care systems differ from Member State to Member State. Nonetheless, it has been argued in legal doctrine that national health care systems in the EU can be divided into two main categories: National Health Services (NHS) and Social Insurance Systems.³ Member States like the United Kingdom and Spain have introduced a NHS. Such a system is financed by taxes and operates according to a benefit-in-kind-system. At the heart of Social Insurance Systems is compulsory insurance. This implies that all citizens, or particular groups of person, are obliged to be affiliated with a health insurer; such as a sickness fund. In the Netherlands a market-oriented Social Insurance system is in place;⁴ all inhabitants of the Netherlands have the obligation to conclude agreements with private insurance companies. Accordingly, the managing bodies are private insurers in the Dutch health care system, but they have to provide health insurance according to principles of open enrolment and private insurers are the managing bodies (with regard to the basic health care scheme).

It is apparent from the foregoing that there is no such thing as a coherent set of principles of EU health law. However, it must be noted that the systems do have one particular value in common. An important point is that every citizen should have access

³ See for instance TK Hervey and JV McHale, *Health Law and the European Union*, Cambridge 2004, p 21.

⁴ The Dutch health care system was introduced by the Zorgverzekeringswet (Health Insurance Act). See for a short description of this Act: GJ Hamilton, 'A new Private Universal Health Insurance in the Netherlands' in: A den Exter, *Competitive Social Health Insurance Yearbook 2004*, Rotterdam, 2005, p 8 *et seq.*

to necessary health care. Hence, universal coverage is an important issue in the health care systems of the EU Member States. It should be noted that in its case law the ECJ has acknowledged as well that universal coverage is of great importance. In *Smits-Peerbooms*, for example, it was accepted that a Member State must be entitled to plan a network of hospitals covering its whole territory since ‘the survival of the population’ is dependent on such a network.⁵ Apparently, a balanced medical and hospital service open to all must be ensured.⁶

In the light of this case law it was surprising that in 2006 the Council adopted a Communication on common values and principles in the health care systems of the Member States and noted that universality was such a shared value:⁷ no-one should be barred access to health care and access for all must be ensured.⁸ In its Health Strategy adopted in 2007 the Commission stressed the importance of universal coverage.⁹ Furthermore, Article 35 of the Charter of the Fundamental Rights of the European Union provides that ‘everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices’. Consequently, universal coverage is regarded as an important value in European law and is defined as allowing access for all to the necessary health care benefits. It goes without saying that it differs from Member State to Member State which benefits are deemed to be necessary, but it is beyond doubt that all Member States share the value that all their inhabitants are entitled to a minimum level of health care benefits.¹⁰ Although the definition of these benefits is open to debate, universal coverage as such is not called into question.

Subsidising, funding and financially supporting health care are powerful tools for Member States to guarantee universal coverage. This value may be put under pressure if these tools are found to infringe Article 87 EC. Therefore, it could be argued that health care interests are accommodated in the application of the European state aid rules where the objective of universal coverage is integrated into the way the Community Courts and the Commission deal with the Treaty provisions on state aid. Moreover, taking into account this objective would contribute to respecting the health care powers of the Member States. After all, their national authorities remain competent to financially intervene on health markets in order to guarantee access for all to the necessary benefits. This would also be in line with the new provision on the Member States’ health care competences inserted by the Treaty of Lisbon, which inter

⁵ Case C-157/99 *Smits en Peerbooms*, [2001] ECR I-5473, para 74. See also C-385/99 *Müller-Fauré* [2003] ECR I-4509, paras 79 and 80 and C-372/04 *Watts* [2006] ECR I-4325, para 111.

⁶ *Smits-Peerbooms*, *ibid*, para 73. See also *Müller-Fauré*, *ibid*, para 67 and *Watts*, *ibid*, para 104.

⁷ The Council Conclusions on Common values and principles in European Union Health Systems, OJ 2006, C156/1.

⁸ *Ibid*.

⁹ White Paper, ‘Together for Health: A Strategic Approach for the EU 2008-2013’ COM (2007) 630 final, p 3.

¹⁰ C.f. AP van der Mei, *Free Movement of Persons within the European Community. Cross-Border Access to Public Benefits*, Oxford, 2003, pp 4 & 5.

alia provides that the responsibilities of the national authorities shall include the allocation of the resources assigned to health services.

Below, it is examined to what extent concerns of universal coverage play a role in the application of the European State aid rules. Firstly, the concept of undertaking, which is the ‘gate’ to the state aid rules, will be explored. Subsequently, attention will be paid to Articles 87-89 EC.

3. THE CONCEPT OF UNDERTAKING IN HEALTH CARE: ARE THE EUROPEAN STATE AID RULES APPLICABLE TO HEALTH CARE OPERATORS?

It is settled case law that every entity engaged in economic activities is an undertaking within the meaning of EC competition law.¹¹ In European competition law the concept of undertaking is one of the key jurisdictional tools: it delineates the scope of these rules.¹² How does the ECJ apply this definition to health care cases? This contribution addresses this question by making a distinction between bodies managing health care schemes and health care providers.

When it comes to managing bodies, the ECJ scrutinises whether the health care scheme at issue is almost completely based on the principle of solidarity – in the sense of redistribution of wealth¹³ – or whether elements of competition are built into this scheme.¹⁴ If the principle of solidarity is predominant, the managing bodies are not engaged in economic activities according to the ECJ and, as a result, are not undertakings.¹⁵

The approach of scrutinising the design of the scheme at issue is confirmed by case law that does not concern health care systems but other social security schemes.¹⁶ In *Kattner Stahlbau*,¹⁷ for example, the ECJ examined whether the statutory disability insurance scheme at issue was predominantly based on the principle of solidarity and to what extent this scheme was subject to supervision by the State.¹⁸ In contrast, managing bodies do carry out economic activities, and do fall within the scope of competition

¹¹ See for instance case C-41/90 *Höfner* [1991] ECR I-1979. C.f. also case C-55/96 *Job Center* [1997] ECR I-7119.

¹² V Louri, “‘Undertaking’ as a Jurisdictional Element for the Application of EC Competition Rules”, [2002] Legal Issues of Economic Integration 172.

¹³ A Winterstein, ‘Nailing the Jellyfish: Social Security and Competition Law’ [1999] ECLR 330.

¹⁴ Cf. E Szyszczak, ‘State Intervention and the Internal Market’, in: T Tridimas and P Nebbia, *European Union Law for the Twenty-First Century. Volume 2: Internal Market and Free Movement Community Policies*, Oxford, 2004, pp 232 and 233.

¹⁵ See e.g. joined cases C-159/91 and C-160/91, *Poucet and Pistre* [1993] ECR I-637, joined cases C-264/01, C-306/01, C-351/01 and C-355/01, *AOK et al.*, [2004] ECR I-2493; case T-319/99, *FENIN* [2003] ECR I-357; and, Case C-205/03P, *FENIN* [2006] ECR I-6295.

¹⁶ See e.g. paras 38-46 of Case C-218/00 *Cisal*, [2002] ECR I- 691.

¹⁷ Case C-350/07, *Kattner Stahlbau v Maschinenbau- und Metall- Berufsgenossenschaft*, 5 March 2009, n.y.r.

¹⁸ At para 43. State supervision must ensure that bodies managing the schemes concerned observe the principle of solidarity.

law, if the national legislature has opted for a (balanced) mix of solidarity and market forces in designing the health care scheme concerned.¹⁹

What role does universal coverage play in this case law? In the *FENIN* cases,²⁰ the Community courts ruled that the (Spanish) NHS bodies were not undertakings, as they were funded from social security contributions and other State funding and provided services free of charge to affiliated persons on the basis of universal coverage.²¹ This reasoning shows that solidarity and universal coverage are interlinked in health care cases; as in these types of cases solidarity not only leads to the redistribution of wealth but also amounts to the transfer of financial resources from healthy persons to unhealthy persons. At the end of the day, this is a matter of universal coverage, as access for all to health care benefits is ensured. Consequently, concerns of universal coverage do play a role in the ECJ's case law on the concept of undertaking.

In sum, it may be argued that it depends on the national design of health care schemes whether managing bodies fall within the ambit of EC competition law. The main argument is related to the principle of solidarity but universal coverage is of interest as well;²² since providing access to all may be regarded as an expression of solidarity, as the Community Courts did in the *FENIN* cases. In essence, the Community courts draw from the will of the national legislator when deciding whether competition law should be applicable or not; the test deployed by the ECJ may be referred to as a 'concrete test'. This implies that the powers of the Member States are respected: if they are not willing to introduce (a substantive amount of) competition elements in the design of a health care system, competition rules, including the Treaty provisions on state aid, are not applicable.

In contrast, in cases where health care providers, like doctors and hospitals, are involved the ECJ has developed a different approach to the question of whether these entities fall within the scope of the concept of undertaking. It simply departs from the assumption that health care is (usually) provided for economic consideration and that, as a result, doctors and other health care providers are engaged in economic activities.²³ In *Pavlov*, for example, the ECJ was of the opinion that medical specialists are engaged in economic activities (in their capacity as self-employed economic operators) because they provide services for remuneration.²⁴ Like in *Pavlov*, the ECJ found in *Ambulanx*

¹⁹ See, for example, Case C-244/94, *FFSA* [1995] ECR I-4015; Case C-67/96, *Albany* [1999] ECR I-5751, Joined Cases C-115/97, C-116/97 and C-117/97 *Brentjens* [1999] ECR I-6025 and Case C-219/97, *Drijvende bakken* [1999] ECR I-6121.

²⁰ See Case T-319/99, *FENIN* [2003] ECR II-357 and Case C-205/03P, *FENIN* [2006] ECR I-6295.

²¹ See para 39 of the CFI judgment in Case T-319/99, *FENIN* [2003] ECR II-357.

²² Cf. Winterstein, op cit, n 13, p 330.

²³ See Joined Cases C-180-184/98, *Pavlov* [2000] ECR I-6451 and case C-475/99, *Ambulanx Glöckner* [2001] ECR I-8089.

²⁴ See point 76 of *Pavlov*, ibid.

Glückner that the medical aid organizations concerned were undertakings because they provided services for economic consideration.²⁵

Remarkably, in these cases the ECJ does not examine the concrete legal framework applicable to the health care providers concerned. It merely records that health care services may be offered to end users via market mechanisms. By doing so, the ECJ deals with the definition of economic activities and health care providers in a rather abstract way. Therefore, the test applied to these providers may be regarded as an abstract test.

Consequently, the ECJ almost automatically regards health care providers as undertakings within the meaning of European competition law. In other words, these providers cannot escape from the competition rules. As a result, concerns of universal coverage do not play a role in the ECJ's case law on the concept of undertaking and to health care providers.

In the light of the foregoing, it has to be concluded that, in its case law, the ECJ makes a distinction between managing bodies (such as National Health Care authorities and sickness funds) and health care providers.²⁶ It appears from the analysis of this case law that the ECJ uses the concept of undertaking as flexible jurisdictional tool to exclude solidarity-based health care systems from the ambit of European competition law, when it comes to managing bodies.²⁷ Conversely, the role of this tool is neglected if the competition rules are applied to health care providers. Therefore, in this contribution separate sections deal with managing bodies and providers below. But first, the main features of the state aid provisions of the EC Treaty are outlined.

4. THE EUROPEAN STATE AID RULES: GENERAL REMARKS

Pursuant to Article 87(1) EC Member States are not allowed to grant state aid to undertakings that distorts competition on the Common Market and influences intra-Community trade. However, in European state aid law things are not as black and white as they appear. The fact is that the Commission has the power to approve national state aid measures on the basis of Article 87(3) EC. For example, according sub para (c) of this Treaty provision national aid measures facilitating 'the development of certain economic activities or of certain economic areas' may be allowed. Furthermore, Article 86(2) EC, which deals with Services of General Economic Interest (hereafter SGEI), provides for an exemption from the prohibition laid down in Article 87(1) EC. The Commission has the power to approve state aid measures because these measures fulfil the conditions of Article 86(2) EC. Evidently, national state measures will only benefit from these exemptions if they are notified by the

²⁵ See point 20 of *Ambulanz Glückner*, op cit, n 23.

²⁶ See also JW van de Gronden, 'Purchasing health care: economic activity or Service of General (Economic) Interest' [2004] ECLR 84-86.

²⁷ Cf. also V Louri, op cit, n 12, p 174, and E Szyszczak, 'Modernising Healthcare: Pilgrimage for the Holy Grail?' in M Krajewski, U Neergaard and JW van de Gronden, *The Changing Legal Framework for Services of General Interest in Europe. Between Competition and Solidarity*, The Hague, 2009, p 21.

Member States to the Commission. In the absence of notification, the Commission has the authority to order repayment of the aid concerned.²⁸ Domestic courts are even obliged to apply the standstill provision of Article 88(3) EC, which implies that they must also order the recovery of illegal state aid granted by the Member States' competent authorities.²⁹ It goes without saying that the standstill provision could lead - at least potentially - to far-reaching legal problems with regard to financing mechanisms concerning general interest policies. In a worst case scenario many enterprises entrusted with special tasks related to goals of public interest are faced with actions of repayment and, as a result, with deficits on their budgets.

In this regard, it must be noted that the ECJ has developed a special approach towards state aid and issues of general interest built upon the concept of SGEI. In *Altmark*,³⁰ it held that compensatory measures for the execution for Public Service Obligations (hereafter PSO) do not constitute state aid, provided that the following conditions are met: (1) the undertaking in question is charged with the execution of a PSO, (2) the parameters of the amount of the compensation are established in an objective and transparent way (3) the compensation does not go beyond what is necessary, and (4) in the case that the public contract concerned is not subject to a public procurement procedure, the amount of the compensation is determined on the basis of the expenses a well-run undertaking would have incurred. Compensation measures that comply with these criteria are not regarded as state aid in the sense of Article 87 (1) EC. A major advantage of the approach developed in *Altmark* is, therefore, that these benefits do not need to be notified to the Commission.

It may be argued that by delivering its judgment in *Altmark* the ECJ has developed a jurisdictional approach to state aid. After all, financial measures that fulfil the conditions outlined in this ruling are simply not caught by the prohibition laid down in Article 87(1) EC. Moreover, the reasons that may lead to the non-applicability of this prohibition are - to some extent - related to concerns of universal coverage. After all, in many circumstances the aim of PSO is to enable particular operators to provide services to all at affordable rates.³¹ However, the jurisdictional approach in *Altmark* does not offer the Member States carte blanche as the conditions set by the ECJ in this ruling must be fulfilled. The public authorities of the Member State must make the estimation whether PSO benefits do meet these conditions. If so, they do not have to initiate a notification procedure. What is more, in cases where the legality of compensation measures is at stake, it may be argued before domestic courts that these measures are justified in the light of the *Altmark* criteria and, as a consequence, must not be recovered by the enterprise entrusted with the execution of PSO. Hence, the

²⁸ Article 14 of Regulation 659/1999 laying down detailed rules for the application of Article 93 of the EC Treaty, OJ 1999, L83/1.

²⁹ See e.g. case C-39/94, *La Poste*, [1996] ECR I-3547.

³⁰ Case C-280/00, *Altmark*, [2003] ECR I-7747.

³¹ Cf. W Sauter, 'Services of general economic interest and universal service in EU law' (2008) 33(2) *ELRev* 167.

Altmark approach is capable of solving enormous legal problems that may result from the standstill provision laid down in Article 88(3) EC.

The *Altmark* approach could be of great interest for health care, as universal coverage plays a major role in this sector. However, much depends on how the Community courts interpret the *Altmark* criteria. If they depart from a strict reading of the *Altmark* judgment many national compensation measures will be found incompatible with Article 87(1) EC. As a consequence, the proper execution of many PSOs will be put at risk due to the standstill provision of Article 88(3) EC. Conversely, a flexible interpretation of the *Altmark* criteria will prevent these problems from occurring. How do the Community courts and the Commission deal with this matter in health care? This question is addressed in the following sections.

5. STATE AID AND MANAGING BODIES IN HEALTH CARE

It may be expected that the question of whether a particular health care operator is entrusted with a special task is crucial in the decisions taken with regard to the financing of health care. After all, the first *Altmark* condition concerns the charge of the execution of a PSO. The analysis of these decisions carried out below will show whether this is the case. Given the different ‘undertaking tests’ applied by the ECJ to managing bodies and health care providers, the role that *Altmark* plays in health care will be explored in separate sections, as already mentioned. This section deals with financing mechanisms for special tasks entrusted to managing bodies.³²

5.1. State aid and state oriented health care systems

To start with, it is important to examine whether the European state aid rules are applicable. Above, it was pointed out that according to the jurisdictional approach developed by the ECJ with regard to the concept of undertaking health care schemes, in which the principle of solidarity is predominant, do not amount to economic activities. Consequently, benefits granted by public authorities to bodies managing these schemes do not fall within the ambit of Article 87(1) EC, which implies that these benefits do not need to be notified to the Commission.

Remarkably, it is apparent from the *AOK* judgement³³ that the ECJ quite easily assumes that health care systems are mainly based on the solidarity principle. In this case the ECJ decided that German sickness funds were not undertakings by referring to the following three reasons. Firstly, the insured persons are only entitled to benefits that are fixed by the State (obligatory benefits).³⁴ Apparently, the German health care system does not allow for competition on the benefits that sickness funds offer to affiliated

³² This section focuses on financial advantages granted to managing bodies such as health insurers. Therefore, it does not deal with premium reductions that public health insurers grant in order to support enterprises (facing fierce competition on the internal market). This issue is discussed in E Mossialos, M McKee, W Palm, B Karl and F Marhold, *EU law and the Social Character of Health Care*, Brussels, 2002, p. 184-186.

³³ Joined cases C-264/01, C-306/01, C-351/01 and C-355/01, *AOK et al.*, [2004] ECR I-2493.

³⁴ *Ibid*, para 45-65.

persons. Secondly, the German sickness funds are non-profit organisations. Amazingly, the ECJ did consider the condition of profit making irrelevant in *FFSA*,³⁵ this condition has made a 'come back' in the *AOK* judgment. Thirdly, the German sickness funds are engaged in a system of risk equalisation. Under such a system sickness funds with less healthy persons are compensated for the costs incurred because of these persons by funds with more healthy persons.

In this writer's view Member States can escape from the applicability of the EC state aid rules by introducing state oriented interventions in their health care schemes. As in *Poucet and Pistre*,³⁶ the ECJ is of the opinion in *AOK* that obligatory benefits indicate solidarity and the absence of economic activities. In this respect it is of interest that such benefits do not bear relation to the amount of the contributions paid by the affiliated persons. Hence, if the objective of universal coverage is achieved by fixing the level of benefits in national legislation, the managing bodies concerned are not undertakings and financial support granted to them falls outside the scope of the Treaty provisions on state aid.

Remarkably, in the view of the ECJ, the fact that the German sickness funds were engaged in some price competition did not call into question the finding that these funds are not undertakings. Hence, it may be concluded that many state oriented health care systems - especially those that do not leave room for competition on benefits due to their obligatory nature - are not affected by Articles 87-89 EC. This conclusion is endorsed by the outcome of the *FENIN* cases. Here, both the CFI and ECJ ruled that the managing bodies of the Spanish National Health Service were not engaged in economic activities, as these bodies are obliged to provide health care free of charge. Above, it was pointed out that concerns of universal coverage were closely related to the principle of solidarity in this case. In *FENIN*, the Community courts even held that the purchase activities of the managing bodies of the Spanish National Health Service did not fall within the scope of EC competition law, since their subsequent use (i.e. granting benefits to affiliated persons free of charge) was not of an economic nature. This means that funding granted to these managing bodies does not fall within the scope of the European State Aid rules and, as a result, there is no need to set up a system of separate accounting for purchase activities, but financial support given to the business partners of the managing bodies, i.e. the health care providers, does have to comply with Articles 87-89 EC.

From the foregoing it is apparent that a health care system that is almost only based on the principle of solidarity does - completely - escape from the EC rules on state aid (and competition), as even purchase activities of its managing bodies are also not of an economic nature. It must, however, be noted that this conclusion holds true in so far as - apart from their task to provide basic health care services - these managing bodies do not offer additional commercial health care policies.

³⁵ Para 21 of Case C-244/94, *FFSA* [1995] ECR I-4015.

³⁶ Para 18 of *Poucet and Pistre*, op cit, n 15.

5.2. State aid and market oriented health care systems

Articles 87-89 EC only come into play when a Member State has introduced a health care scheme based on a mix of solidarity and competition. To what extent do the Community Institutions accommodate concerns of universal coverage in their review of national financial measures in the light of the European state aid rules? For the purpose of answering this question the *Zorgverzekeringswet* and *BUPA* cases are of relevance. These cases are discussed below.

5.2.1. The *Zorgverzekeringswet* case

In the EU the most striking example of a ‘mixed solidarity and competition based health care system’ is the Dutch Health Insurance Act (hereafter: *Zorgverzekeringswet*). Under the Dutch system private insurance companies are the managing bodies of the basic health care scheme. They are allowed to be for-profit and, accordingly, it may be assumed that they are undertakings. This conclusion is endorsed by the Commission in its decision concerning state aids granted in the health care system introduced by the *Zorgverzekeringswet*.³⁷ In the view of the Commission, the most important element regarding the concept of undertaking was that the Dutch insurance companies were allowed to aim for-profit. By stressing the fact that that Dutch health care schemes were administered by for-profit insurers, the Commission built on the ECJ’s finding in *AOK* that profit making should be regarded as a significant condition for applying the concept of undertaking. Furthermore, it was taken into consideration that the Dutch health insurance companies were able to influence the rates of the contributions and to determine the level of benefits granted to insured persons. In the Dutch health care system there is room for competition on benefits, which is an important argument for considering entities as undertakings.

Consequently, the flows of funds of the Dutch health care system must comply with the Community rules on state aid. Like the German sickness funds, Dutch private insurers are obliged to be engaged in a risk equalisation scheme. This scheme was managed by a state body and, as a result, payments made within the framework of that scheme amounted to state aids. In the view of the Commission those payments fall within the scope of the prohibition laid down in Article 87(1) EC. In its decision in *Zorgverzekeringswet* the Commission argued that the Dutch risk equalisation scheme did not benefit from the *Altmark* approach, because the fourth condition (costs of a well-run company) was not fulfilled.³⁸ It was put forward that all insurance companies are entitled to a similar amount of compensation irrespective of the fact whether they operate in an efficient or inefficient way. The Commission contended that the Dutch risk equalisation scheme aimed at tackling all problems of risks and not at compensating costs. As a consequence of the Commission’s approach it may be argued that a compensation scheme directed at an open group of operators usually fails to

³⁷ Decision of the Commission of 22 December 2005 on the introduction of a risk equalisation system in the Dutch Health Insurance, N541/2004 and N542/2004 – C (2005) 1329 fin.

³⁸ Section 3.4.1 of the Commission decision in *Zorgverzekeringswet*, *ibid*.

meet the fourth *Altmark* condition. After all, it is hardly possible for the competent health care authorities of the Member States to set up general compensation schemes that take due account of the individual costs of efficient companies.

The strict reading by the Commission of the fourth *Altmark* condition leads to the non-applicability of the jurisdictional approach developed in this case. Due to the competition elements introduced in the design of the Dutch health care system the jurisdictional approach developed in relation to the concept of undertaking cannot be of any help. This system also does not benefit from the jurisdictional approach of *Altmark*. An important consequence of this is that due to the standstill provision such general schemes must be notified to the Commission before they can be put into operation. This enables the Commission to regulate and monitor national compensatory measures taken by Member States in the framework of health care systems based on a mix of solidarity and competition. One could, therefore, argue that in the Dutch health care system competition is not only regulated by national public authorities (entrusted with this task by the Dutch legislator) but also by the European Commission. All the same, the Commission approved the Dutch risk equalisation scheme, since it went on by reviewing this scheme in the light of Article 86(2) EC. In its view all health insurance companies were entrusted with a SGEI mission in spite of the lack of an official and explicit act of entrustment. The special task was derived from general obligations imposed upon the insurers by the Dutch Health Insurance Act. The obligations related to open enrolment, community rating, benefits granted to insured persons, and supervision mechanisms amount to the entrustment of SGEI within the meaning of Article 86(2) EC. As far as the writer of this contribution is aware, this is the first time that a Community institution derives a SGEI mission from the wording of obligations of a general nature. This is remarkable since it is common ground that such a mission should be entrusted by an explicit positive act.³⁹ Above, it was noted that it may be expected that explicit entrustment should be an important element of consideration. It turns out that this is not the case with the present Commission decision. In any event, the Commission contended that the risk equalisation scheme was necessary in order to solve problems of adverse selection. Such a scheme removes incentives for health insurers to direct their commercial and market strategies at healthy people ('low risks') and to develop policies aiming at preventing unhealthy people ('high risks') from enrolling.⁴⁰ Hence, at the stage of justification, i.e. in applying Article 86(2) EC, the Commission was prepared to justify the Dutch risk equalisation scheme. It is clear that a decisive argument for this justification was the objective of universal

³⁹ On this elementary matter, see, for example, A Jones & B Sufrin, *EC Competition Law*, 3rd ed, Oxford, 2008, p 653 and R Whish, *Competition Law*, 6th Ed, Oxford, 2009, p 234. See also para 22 of the Communication from the Commission, Services of General Interest in Europe, OJ 2001, C17/4, and 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', SEC(2007) 1516, p 21.

⁴⁰ See section 4.2.2.1 of the Commission decision in *Zorgverzekeringswet*.

coverage. After all, the aim of the risk equalisation scheme at stake was to insure all inhabitants of the Netherlands: not only healthy persons but also unhealthy persons should get access to the necessary benefits.

The taking into account the objective of universal coverage at the justification stage has a price. This is apparent from the way in which the Commission carried out the proportionality test. In its view the payments made in the framework of the Dutch risk equalisation scheme were proportionate. An important consideration was that the scheme concerned was based on *ex ante* correction (the costs of the insurance companies having 'high risks' are compensated in advance) and *ex post* correction was only possible in limited circumstances. It should be noted that *ex ante* equalisation leaves more room for competition than *ex post* equalisation, since compensation paid in advance does not cover all costs, whereas the point of departure of compensation paid afterwards is coverage of all expenses incurred by the health care insurers involved. Implicitly, in *Zorgverzekeringswet* the Commission gave the signal that *ex ante* equalisation is preferred to *ex post* equalisation. Hence, it cannot be excluded that the Dutch government will face difficulties from the Commission, if it decides to change the correction mechanisms of the risk equalisation scheme and to go for an *ex post* system. By assessing the measure concerned at the justification stage the Commission had the power to influence core elements of the Dutch health care system. On the one hand, it respected the health care competence of the Dutch government by interpreting Article 86(2) EC extensively but on the other hand it has the power to influence significant features of the Dutch system. It is not clear from the outset to what extent this is in line with Article 152(5) EC that stipulates that the organisation and delivery of health care belong to the competences of the Member States.

The decision of the Commission was challenged by a Dutch insurance company, *Azivo*.⁴¹ Unfortunately, the case was removed from the register of the CFI, and as a result, the Community courts did not have the opportunity to assess whether the Commission's approach towards the *Altmark* judgement is correct. In this regard, it is a pity that the Dutch government did not bring the *Zorgverzekeringswet* case before the CFI. It could have called into question the Commission's position that the flow of funds resulting from the risk equalisation scheme constitutes state aid within the meaning of Article 87(1) EC. An interesting line of reasoning would have been that the Commission applied the fourth *Altmark* condition (the costs of a well-run company) too strictly. This is a question of principal, since the consequence of the Commission's approach is, as already pointed out above, that general compensation schemes cannot benefit from the *Altmark* judgement. If the Commission's point of view is not correct, these schemes could escape from the applicability of the state aid rules and, as a result, from the state aid control by the Commission.

⁴¹ Case T-84/06, OJ 2006, C108/27.

5.2.2. The BUPA case

Although, the Community courts did not review the Commission's decision in *Zorgverzekeringswet*, the CFI did deliver its judgement in a similar case: *British United Provident Association* (hereafter: BUPA).⁴² At issue was an Irish risk equalisation scheme that was approved by the Commission. The Commission's decision was adopted before the ECJ delivered its *Altmark* judgement and was, therefore, based on its (now out-dated) *Ferring* ruling.⁴³ The criteria of the latter were vague and unclear, which compelled the CFI to review the Irish compensation mechanisms in the light of the *Altmark* conditions. Hence, the CFI was confronted with the question of the applicability of the concept of PSO in health care. What was the CFI's stance towards PSO and risk equalisation?

At first, the remarkable differences between the Irish and the Dutch risk equalisation schemes must be outlined for a good understanding of the decision taken by the CFI in BUPA. In Ireland a system based on private insurance operates alongside a tax-financed public health care system.⁴⁴ It is an alternative system of coverage for private medical treatment. So Irish inhabitants may opt for a public or a private scheme. Like the Dutch system, private insurance companies have to comply with obligations such as open enrolment and community rating. On top of that they are obliged to participate in a risk equalisation scheme. However, unlike the scheme at stake in *Zorgverzekeringswet*, the Irish mechanisms amounted to *ex post* compensation.⁴⁵ As compensation paid afterwards is based on the coverage of actual costs, it tends to reduce incentives to compete.⁴⁶

In sum, the Dutch and Irish schemes are different in two respects. Firstly, the private Irish insurance companies provide alternative cover to that provided by public health insurance system, whereas the Dutch private insurers are the only managing bodies. Secondly, the Irish risk equalisation scheme is based on *ex post* compensation and the Dutch scheme (mainly) on *ex ante* compensation.

In the light of these differences, it is striking that in the view of the CFI the Irish equalisation scheme did meet all *Altmark* conditions. The CFI started off by putting forward that the Member States' public authorities have a wide margin of appreciation in entrusting undertakings with special tasks. Community institutions are only entitled to examine whether these authorities make manifest errors when designating PSO. Given this point of departure it is not a surprise that in the view of the CFI all the *Altmark* condition were fulfilled in BUPA. The liberal approach of the CFI may be illustrated by discussing the CFI's considerations with regard to the fourth *Altmark* condition, which played such an important role in *Zorgverzekeringswet*. It was stated that

⁴² Case T-289/03, *British United Provident Association* [2008] ECR II-81.

⁴³ Case C-53/00, *Ferring* [2001] ECR I-9067.

⁴⁴ Case comment on BUPA by W Sauter, (2009) 46(1) CMLRev 269, p 273.

⁴⁵ Para 33 of BUPA, op cit, n 42.

⁴⁶ See Sauter, op cit n 44, p 275.

this condition could not be applied strictly in the present case.⁴⁷ The reason for this differentiating approach was that the Irish scheme is neutral with respect to the costs. Its point of departure is the issue of the additional costs associated with negative risk profiles. As long as the equalisation does not lead to ‘offsetting any costs that might result from inefficiency’ on the part of the private insurers subject to scheme concerned, the fourth *Altmark* condition is not disregarded.⁴⁸ The CFI’s conclusion was that the Commission’s decision did not disrespect the reformulated *Altmark* condition and that, therefore, the payments made in the framework of the Irish scheme at stake did not constitute state aid.

It is clear from the outset that the CFI preferred to apply a jurisdictional approach by relying upon a lenient reading of the *Altmark* conditions. In its view bodies managing a health care scheme based on both competition and solidarity elements may benefit from the jurisdictional approach of *Altmark*. As a result, the health care competences of the Member States are respected more than under the review carried out by the Commission in *Zorgverzekeringswet*. It cannot be ruled out that the CFI was inspired by the wording of Article 152(2) EC that aims at safeguarding these national competences. In the light of the foregoing, one cannot not help thinking that the Dutch government missed an opportunity by not challenging the Commission’s decision in *Zorgverzekeringswet*. The CFI has given the Member States considerable leeway to regulate PSO in health care⁴⁹ and –by doing so– narrowed down the Commission’s possibilities to intervene on the basis of the European state aid rules. Under the *BUPA* approach, of the CFI, many compensation measures do not amount to state aid and do not need to be notified to the Commission. If the Commission’s *Zorgverzekeringswet* decision was annulled, the Dutch health care regulations on competition and risk equalization would not have been subjected to the Commission’s supervision.

It should be noted that the Commission’s decision in *Zorgverzekeringswet* and the CFI judgement in *BUPA* also have a lot in common. It has been pointed out that the Commission derived a SGEI mission from the wording of general obligations laid down in national legislation. In *BUPA* the CFI followed the same method. It argued

⁴⁷ By doing so, the CFI moderated the fourth *Altmark* condition. In legal doctrine, it was put forward that the fourth condition was hard to fulfill, as it is difficult to ascertain what a reasonable profit is. See e.g. A Biondi, ‘The financing of Services of General Economic Interest’ in T. Tridimas and P. Nebbia, *European Union Law for the Twenty-First Century. Volume 2: Internal Market and Free Movement Community Policies*, Oxford, 2004, p 270; p 46 of the study ‘Internal market and Health Care: a new balance?’ conducted in 2006 by Université Libre de Bruxelles in collaboration with the Katholieke Universiteit Leuven on the request of Rudy Demotte, Minister of Public health and Social affairs, Belgium; M Krajewski, ‘Providing Legal Clarity and Securing Policy Space for Public Services through a Legal Framework for Services of General Economic Interest: Squaring the Circle?’ (2008) *European Public Law* 390; and, V Hatzopoulos, ‘Services of General Interest in Healthcare: An Exercise in Deconstruction?’ in U Neergaard, R Nielsen and LM Roseberry, *Integrating Welfare Functions into EU law-From Rome to Lisbon*, DJØF Publishing, Copenhagen, 2009, p 233. Apparently, in *BUPA* the CFI contradicted this point of view.

⁴⁸ Para 249 of *BUPA*, op cit, n 42.

⁴⁹ Cf. W Sauter and H Schepel, *State and Market in European Union Law. The Public and Private Spheres of the Internal Market before EU Courts*, Cambridge, 2009, p 191, footnote 191.

that in providing medical health insurance services the private insurers operating in Ireland had to comply with obligations such as community rating, open enrolment, lifetime cover and minimum benefits. In the view of the CFI these obligations amount to the entrustment of special tasks.⁵⁰ Remarkably, the CFI even accepted as common ground the notion that the concept of PSO corresponds to that of SGEI under Article 86(2) EC and stated that ‘it does not differ from that referred to in Article 86(2) EC.’⁵¹ Hence, the CFI’s point of view on PSO sheds additional light on SGEI missions. It may be argued that, like the Commission, the CFI is of the opinion that SGEI missions may be derived from general obligations and that in *BUPA* the concept of SGEI is broadened. A consequence of the method deployed in *BUPA* is that an open group of operators may be entrusted with a SGEI mission. The Commission’s point of view that all insurance companies could be entrusted with SGEI is supported by the *BUPA* case. This is an important conclusion for the health care sector, as in this sector an open group of operators is supposed to realise objectives of general interest.

It is clear that the rationale of deriving SGEI missions from general obligations is the objective of universal coverage. The aim of the Irish system was to provide access to health care benefits to all. However, the necessity for this was not as compelling as in the Dutch system, since the inhabitants of Ireland had the possibility to take out insurance either from the statutory scheme or from the supplementary scheme that was subject of review in *BUPA*. Hence, since the statutory scheme provided a fallback option, it could be questioned whether universal coverage would be put under pressure without financing the private insurance companies involved. The CFI’s judgment does not shed any light on this matter and, as a result, the way it dealt with PSO in *BUPA* is ambiguous. This does not contribute to the proper understanding of the concept of PSO in health care. The question arises whether SGEI missions or PSO still need to be derived from explicit official acts or whether general obligations related to public interest issues suffice. If the latter is the case, many health care operators are entrusted with SGEI missions and PSO and can be financially supported by state bodies, which may have adverse effects on competition. Whereas the Commission has developed a rather strict approach, the CFI seems to open the door to several kinds of competition distorting measures by considerably extending the scope of the concepts of SGEI missions and of PSO. However, in its recent judgment in a case concerning state aid granted in Italy, the CFI has demonstrated that there are some limits to its flexible approach by holding that a SGEI cannot be derived from the mere fact that the undertakings concerned pursue activities in the public economic interest.⁵² The problem was that the Italian law at issue did not contain any definition of a specific measure or any obligation related to a special task. Moreover, it was not made clear at all which public service obligations were involved. So, merely claiming that the public

⁵⁰ Para 182 of *BUPA*, op cit, n 42.

⁵¹ Paras 161 & 162 of *BUPA*, op cit, n 42.

⁵² Para 113 of Case T-222/04, *Italy v Commission*, 11 June 2009, n.y.r.

interest is involved without putting forward any substantiated evidence will not help Member States to escape from the European state aid rules.

Of further importance is the *TV2/Danmark* ruling.⁵³ In this case the CFI also derived a SGEI mission from general obligations laid down in the Danish media legislation. Hence, the approach developed in *TV2/Danmark* is comparable to the method used in *BUPA*. Conversely, it must be pointed out that in *TV2/Danmark* only one operator was entrusted with a special task, as this case concerned activities carried out by a broadcasting company. In the broadcasting sector, public authorities usually entrust SGEI missions to a limited number of operators. In any event, in *TV2/Danmark* the CFI confirmed its rather lenient (and to a certain extent confusing) approach towards SGEI missions deployed in BUPA.

6. STATE AID AND HEALTH CARE PROVIDERS

In section 4 it was pointed out that the ECJ easily assumes that health care providers are engaged in economic activities and should be regarded as undertakings. As a result, financial benefits granted to health care providers constitute state aid within the meaning of Article 87(1) EC. Member States are, therefore, obliged to assess all financial support given to hospitals, physicians etc, in the light of this provision irrespective of the fact that the applicable legal framework is predominantly based on concerns of solidarity and universal coverage. If they fail to do so, they risk that – on the basis of the stand still provision laid down in Article 88(3) EC – national courts or the Commission will order recovery of aids paid to these providers.

How can national public authorities responsible for financing health care providers deal with the problems resulting from the EC rules on state aid? In this writer's view, two approaches are possible. In the first place, they could consider notifying state aid measures to the Commission before putting them into practice. However, it is clear that such a notification process is time-consuming. Moreover, notification procedures give the Commission the opportunity to influence the organisation and financing of national health care systems, by, for example, obliging national health care authorities to introduce market elements into their financial support schemes. It goes without saying that this will not be much appreciated by many national health care authorities. In the second place Member States may argue that the EC state aid rules are not applicable to the financial support given to health care providers. For example, it could be put forward that providers such as hospitals operate on nationally oriented markets, which means that intra-Community trade is not influenced. It is apparent from the *Pearle* judgement⁵⁴ that state aid measures that do not have any effect on the trade between Member States, do not fall within the ambit of Article 87(1) EC and are, as a consequence, not subject to the notification obligation laid down in Article 88(3) EC. This line of reasoning could also lead to a jurisdictional approach; the main argument is

⁵³ Joined Cases T-309, 317, 329 & 336/04 *TV2/Danmark v Commission*, [2008] ECR II-2935.

⁵⁴ Case C-345/02, *Pearle* [2004] ECR I-7139.

that the prohibition laid down in Article 87(1) EC is not applicable due of the lack of an effect on intra-Community trade. Another possibility is to argue that the financial advantages compensate the execution of PSO and do not fall within the ambit of Article 87(1) EC because these advantages fulfil the *Altmark* conditions. It is clear from the outset that this line of reasoning is based on the jurisdictional approach developed in *Altmark*. Below, both defences (the absence of any effect on intra-Community trade and the *Altmark* approach) will be discussed.

6.1. Aids granted to hospitals and intra-Community trade

It is risky to assume that the trade between Member States is not influenced. Since 1998, the ECJ has delivered judgments on the free movement provisions of the EC Treaty and cross-border health care.⁵⁵ It has held that the competent authorities of a Member State may not make non-hospital care received in other Member States subject to prior authorisation.⁵⁶ In contrast, prior authorisation schemes may be applied to hospital treatments that patients undergo in other Member States.⁵⁷ However, if patients cannot be treated in domestic hospitals without undue delay, the competent authorities are not entitled to refuse treatment abroad and are obliged to reimburse the costs related to this treatment. Hence, the EC free movement rules are capable of opening up national health care markets and of inducing dynamic cross-border developments on these markets. These effects may be even reinforced by the Draft directive on patient mobility.⁵⁸ The Commission published this draft on July 2, 2008 and it may be regarded as a follow-up to the ECJ's case law on cross-border health care. The proposed directive *inter alia* aims at codifying the well-known judgments on hospital treatment in other Member States. But by doing so, it alters the approach developed by the ECJ. Pursuant to Article 8 of the proposed Directive Member States are allowed to provide for a system of prior authorization for reimbursement of the costs of hospital care in other Member States. However, the following conditions must be fulfilled: first, the costs of the treatment concerned must be covered by the national social security system at issue; second, the aim of the prior authorization scheme must

⁵⁵ See e.g. Case C-158/96, *Kohll* [1998] ECR I-1931; Case C-120/95, *Decker* [1998] ECR I-1831; Case C-157/99, *Smits en Peerbooms* [2001] ECR I-5473; Case C-385/99, *Müller-Fauré* [2003] ECR I-4509; and, Case C-372/04, *Watts* [2006] ECR I-4325. See for a general discussion of this case law for example: V Hatzopoulos, 'Killing national Health and Insurance systems but healing patients? The European market for health care services after the Judgments of the ECJ in *Vanbraeckel* and *Peerbooms*', (2002) CMLRev 683-729; AP Mei, 'Cross-Border Access to Health Care within the European Union: Recent Developments in Law and Policy', (2003) European Journal of Health Law 369-380; A Dawes, 'Bonjour Herr Doctor: National Healthcare Systems, the Internal Market and Cross-border Medical Care within the European Union', (2006) Legal Issues of Economic Integration 167-182 and JW van de Gronden, 'Cross-Border Health Care in the EU and the Organization of the National Health Care Systems of the Member States: The Dynamics resulting from the European Court of Justice's Decisions on Free Movement and Competition Law', 26(3) Wisconsin International Law Journal (2008-2009), 713 *et seq.*

⁵⁶ See e.g. paras 93-98 of *Müller-Fauré*, *ibid.*

⁵⁷ See e.g. paras 72-108 of *Smits-Peerbooms*, *op cit*, n 55; paras 76-92 of *Müller-Fauré*, *ibid.*, and paras 106-123 of *Watts*, *op cit*, n 55.

⁵⁸ Draft Directive on the Application of Patients' Rights in Cross-Border Health Care, COM (2008) 414 final.

be addressing the outflow of patients and preventing the serious undermining of interests such as the financial balance of the national social security systems. At first sight, the second condition seems to be in line with the settled case law of the ECJ. However, the ECJ has never required that Member States should prove that the proper functioning of their hospital systems is undermined by the (possible) outflow of patients. It simply presupposed the serious undermining of these systems as soon as patients seek treatment abroad (provided that they can be treated without undue delay in domestic hospitals). If adopted in its present form, the draft Directive on patient mobility will limit the competences of the Member States considerably,⁵⁹ as they are only allowed to refuse reimbursement of the costs of hospital care undergone abroad in highly exceptional circumstances.⁶⁰ In essence, the Commission confirms this point of view in its Communication accompanying the draft directive, by stating ‘that the additional costs of treatment arising from these proposals are not likely to be such as to undermine the sustainability or planning of health systems overall. This is because citizens are only entitled to be reimbursed for health care that they were entitled to at home, so Member States only have to pay for health care that they would have had to pay for in any case.’⁶¹ As a result, the Draft patient Directive contains a high threshold for introducing a prior authorisation scheme.⁶² In the course of 2009, the European Parliament discussed the Commission’s proposal for a Directive on patient mobility. Numerous amendments were added to the text⁶³ but the requirements regarding the threshold for introducing prior authorisation schemes were not considerably changed. According to the amendments of the European Parliament the Member States must show that ‘the absence of prior authorisation could seriously undermine or be likely to undermine’ the proper functioning of their hospital care systems.⁶⁴ However, at the meeting of 8 and 9 June 2009 the Council did not manage to clinch a deal on the draft Directive.⁶⁵ One of the issues to be addressed by the EU Presidency of the second half of 2009 (Sweden) concerns the matter of prior authorisation schemes.⁶⁶ So, it may be

⁵⁹ JW van de Gronden, ‘Cross-Border Health Care in the EU and the Organization of the National Health Care Systems of the Member States: The Dynamics resulting from the European Court of Justice’s Decisions on Free Movement and Competition Law’, *op cit*, n 55, p 736.

⁶⁰ See also W Sauter, ‘The Proposed Patients’ Rights Directive and the Reform of (Cross-Border) Healthcare in the European Union’ (2009) *Legal Issues of Economic Integration* 125 and JW van de Gronden, ‘Hervormingen in een dienstbaar Europa. Over diensten, uitdagingen en Europees recht (inaugural address)’, Deventer, 2008, pp 50 and 51.

⁶¹ Communication from the Commission, A Community framework on the application of patients’ rights in cross-border healthcare, COM(2008) 415 final, p 9.

⁶² Section 2.1 of R Baeten, ‘The proposal for a directive on patients’ rights in cross-border health care’ in C Degryse, ‘Social developments in the European Union 2008’, Brussels, 2009.

⁶³ European Parliament legislative resolution of 23 April 2009 on the proposal for a directive of the European Parliament and of the Council on the application of patients’ rights in cross-border healthcare (COM(2008)0414 – C6-0257/2008 – 2008/0142(COD)) (codecision procedure – first reading), A6-0233/2009.

⁶⁴ See Amendment 76.

⁶⁵ See the Press Release of the 2947th Council meeting, 9721/09 (Presse 124).

⁶⁶ *Ibid*, p 15.

expected that the final version of the Directive on patient mobility will give the Member States more leeway in regulating hospital care than the current draft does.

In sum, it cannot be excluded that the proposed Directive on patient mobility will stimulate cross-border hospital care. As a result, national health care markets will increasingly become interlinked. Hence, financial benefits granted by national health care authorities to hospitals are more likely to affect intra-Community trade than one would expect. It is clear from the outset that the present case law of the ECJ on cross-border health care is already capable of removing obstacles to the free movement of hospital services and of introducing a level playing field for hospital care on the Internal Market in the EU. Due to the dynamics resulting from the current developments regarding cross-border health care Member States may not assume too easily that state aids granted to hospitals do not affect intra-Community trade and, therefore, do not fall within the scope of Article 87(1) EC.

All in all, arguing that intra-Community trade is affected is not very helpful for accommodating concerns of universal coverage in the application of the European rules on state aid. After all, the term 'intra-Community trade' is of an objective nature and, therefore, does not leave much room for taking these concerns into account.

6.2. Aids granted to hospitals and PSO

However, Member States may also argue that financial benefits granted to hospitals do not need to be notified by referring to the *Altmark* approach. They could put forward that, like bodies managing health care schemes, hospitals are charged with the execution of PSO. It should be noted that relying upon the *Altmark* approach will only be successful, if hospitals are entrusted with a SGEI mission. Consequently, the competent health care authorities of the Member States must take policy measures that assign special tasks to hospitals. Preferably, it should be made clear in national legislation or in decisions taken by public authorities that the hospitals that receive financial support provide SGEI (or are entrusted with the execution of PSO).

In this regard it must be noted that in 2005 the Commission adopted a decision governing state aid and PSO.⁶⁷ This decision concerns compensations that do not benefit from the *Altmark* approach (because one or more conditions outlined in this ruling are not fulfilled). Apart from small public service obligation undertakings,⁶⁸ social housing enterprises and companies operating in air and maritime transport, the 2005 decision is applicable to hospitals. Aids granted to these undertakings are exempted from the notification obligation laid down in Article 88(3) EC. So, at first sight this decision is capable of ensuring universal coverage, since it even justifies financial

⁶⁷ Decision of the Commission of 28 November 2005 on the application of Article 86(2) of the EC Treaty to State aid in the form of public service-compensation granted to certain undertakings entrusted with the operation of services of general economic interest, OJ 2005, L312/67.

⁶⁸ Small public service obligation undertakings are companies with an average annual turnover less than 100 million during the two financial years preceding that in which the service of general economic interest was assigned, which receive annual compensation for the service in question of less than EUR 30 million.

support that does not pass the *Altmark* test. The aim of the Commission is to give Member States more leeway to finance hospital care at the justification stage. However, the decision – in essence – repeats the conditions formulated in *Altmark* by *inter alia* stipulating that the task must be entrusted by way of one or more official acts of public authorities and that the amount of the transfer of money may not exceed what is necessary for the performance of the special task concerned. The decision further specifies the way the special task must be entrusted and how the amount of the compensation must be determined. The rules laid down in the decision are very detailed and strict. In the light of the above-mentioned CFI judgments (such as *BUPA* and *TV2*) the question arises as to whether the Commission's decision on public service obligation has any added value.

The CFI interprets the *Altmark* conditions less strictly than the Commission does. The chance exists that financial benefits granted to hospitals (and other 'public service companies') that meet the requirements set out in the decision also do not constitute state aid within the meaning of Article 87(1) EC because they are also in accordance with the *Altmark* conditions. Hence, the 2005 decision does not extend the possibilities of the Member States to ensure universal coverage at the justification stage; rather it further muddles the concept of SGEI missions.

This is worrying; as opportunistic health care operators may be tempted to engage in litigation in order to challenge financial support given to hospitals. Telling is the case that resulted from a complaint that the private hospital company, Asklepios, lodged with the Commission on 20 January 2003. It was of the opinion that Germany granted illegal state aid to public hospitals. Subsequently, in 2004 it started proceedings before the CFI as the Commission had not taken an official decision with regard to its complaint yet. The Commission argued that the issues raised in this complaint were sufficiently addressed in its (here-above mentioned) 2005 decision on public service compensations. This point of view was rejected by the CFI as the 2005 decision only lays down abstract criteria and does not, by itself, constitute a definition of the Commission on the specific complaint lodged by Asklepios.⁶⁹ However, given the complexity of the case concerned (the German system of financing public hospitals) it could not be argued in the view of the CFI that the Commission was obliged to take a decision within one year.⁷⁰ So, there was no undue delay and the appeal of *Asklepios* was rejected. In sum, at the end of the day the CFI did not review the core elements of the 2005 decision. At time of the writing of this contribution, the follow up to the *Asklepios* case was unclear. The *Asklepios* cases shows that health care operators, such as private hospitals, do not shy away from starting procedures in order to challenge state interventions, by which Member State finance fundamental health care services. This may put the proper functioning of the national health care systems under pressure. In this regard it should be noted that some Dutch hospitals contend that Belgian hospitals are able to offer services to Dutch insured persons at low tariffs because the Belgian

⁶⁹ Para 77 of Case T-167/04, *Asklepios Kliniken v Commission* [2007] ECR II-2379.

⁷⁰ Paras 82-91, *ibid*.

hospital infrastructure is financed at 40% by the Belgian Federal Ministry of Health.⁷¹ So, it may be tempting for Dutch hospitals to challenge one of the core financial interventions of the Belgian health care system.

In 2005 the Commission also published a Community framework for state aid in the form of public service compensation.⁷² In principle, this framework is applicable to all sectors governed by the EC Treaty. In this framework, the Commission stipulates under which conditions it is willing to approve public service compensation on the basis of Article 86(2) EC. They are guidelines regarding the exercise of the competence of the Commission to exempt national state aid measures from the prohibition laid down in Article 87(1) EC. The framework provides that a SGEI mission must be entrusted to the undertaking concerned by way of one or more official acts taken by a state body of a Member State. Furthermore, the amount of compensation may not exceed what is necessary to cover the costs connected with the execution of the SGEI mission concerned. Member States must also provide for checking mechanisms to ensure that there has been no over-compensation. In rather general words the Commission sets out how it will use its powers under the state aid regime in SGEI cases. Like the 2005 Decision, the added value of the Framework to the *Altmark* ruling may be called into question. Consequently, the framework does not shed sufficient light on the role that universal coverage cover may play at the justification stage.

In November 2007 the Commission launched its new single market strategy.⁷³ One of the documents accompanying this strategy addresses state aid - the 'frequently asked questions on state aid and public service obligations' (hereafter "FAQ").⁷⁴ It aims at clarifying the *Altmark* approach. Fortunately, this document provides some important and clear remarks on the way the 2005 Decision of the Commission should be interpreted. It is stressed that, unlike the *Altmark* ruling, the Decision does not require the definition of the amount of the compensation through a public procurement procedure or by comparison with the costs of a well run company. It is sufficient that the compensation is not higher than the net costs connected with the execution of the PSO (no overcompensation). Furthermore, it is stated that the SGEI mission may be described by broad definitions. In this respect, however, it is important that the entrustment allows the correct allocation of costs between SGEI and non-SGEI activities. If it is difficult to estimate all costs, the public authorities of the MS are allowed to apply an *ex post* correction or to update the act of entrustment. It suffices that the act of entrustment includes the basis for the future calculation of the compensation.

⁷¹ V Hatzopoulos, op cit, n 47, p 244.

⁷² Community framework of the Commission for State aid in the form of public service compensation, OJ 2005, C297/4.

⁷³ See the Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions - A single market for 21st century Europe, COM(2007) 725 final. See for further information the next Internet site: http://ec.europa.eu/internal_market/strategy/index_en.htm

⁷⁴ Frequently asked questions on state aid and public service obligations, 20 November 2007, SEC (2007) 1516.

The FAQ sheds more light on the interpretation of the Decision on public service obligations. However, due to the loose application of the *Altmark* conditions by the CFI, it remains unclear whether national compensatory measures falling within the scope of the FAQ would also benefit from the *Altmark* approach. In this regard, it should be noted that in *BUPA* the CFI also moderated the fourth *Altmark* condition (costs of a well run company), like the Commission did in its FAQ in 2007.

All in all, the Community rules governing national compensation measures regarding hospitals are in limbo, as the approaches developed on the EU level contradict each other. Consequently, relying on the *Altmark* approach in order to justify financial benefits granted to hospitals is a dangerous matter. After all, financial advantages that turn out not to be in line with the *Altmark* conditions, must be recovered. It goes without saying that this would put the proper functioning of the hospital network of Member States under enormous pressure.

Member States can, therefore, only avoid legal problems, by notifying their compensatory hospital measures to the Commission. A good example of this approach is the Irish case on financial support and hospitals.⁷⁵ The Irish government had introduced a system of capital allowances for investors in hospitals. The Commission not only contended that the Irish government complied with the standstill obligation by notifying this scheme⁷⁶ but also put forward that the Irish system concerned did not influence intra-Community trade as it mainly served the local hospital market (where a clear undercapacity existed).⁷⁷ However, the author of this paper cannot help thinking that the notification of the Irish system of capital allowances is exceptional and that the vast majority of the financial advantages granted to hospitals has never been made subject to notification procedures. It is to be hoped that despite the lack of clarity of the Community rules on public service compensations these financial advantages do meet the *Altmark* conditions.

7. CONCLUSIONS

The driving force behind the CFI and the Commission decisions on the application of the European State Aid rules to health care cases is universal coverage. The point of departure for this application is the *Altmark* approach that is based on the concept PSO, which is closely related to the need to provide universal coverage. In cases like *BUPA* and *Zorgverzekeringswet* this concept and the notion of SGEI missions have inspired the CFI and the Commission to take due account of health care interests and the competences of the Member States to organise and finance health care. In legal doctrine it is even argued that *BUPA* is a potential step forwards reworking the

⁷⁵ Decision of the Commission of 27 February 2002, State aid No 543/2001 Ireland-Capital Allowances for Hospitals.

⁷⁶ Para 23, *ibid.*

⁷⁷ Para 20, *ibid.*

Community model of competition to include elements of solidarity.⁷⁸ The concepts of SGEI and PSO can play an important role in health care.⁷⁹ Hence, health care concerns are integrated into the way the CFI and the Commission apply Articles 87-89 EC. However, it must be noted that so far the ECJ has not delivered a judgment that clearly settled disputes resulting from tensions between health care objectives and state aid.

Is the EU approach towards health care and state aid fully satisfactory? It could be argued that the jurisdictional approach of the concept undertaking is relatively well developed. This concept gives the Community Courts enough possibilities to accommodate concerns of universal coverage (in relation to solidarity) in the application of the State Aid rules. In contrast, there is one major issue: the simple approach of the concept undertaking towards healthcare providers is not consequent. Hospitals and other providers operating in a solidarity based (legal) framework are undertakings and financial support granted to them must be notified, whereas financial benefits given to managing bodies that administer the schemes of the framework concerned are not subject to the European state aid rules. However, this inconsequent approach will not interfere with the objective of universal coverage, as long as the managing bodies concerned are not engaged in economic activities. Member States may grant financial resources to managing bodies in order to ensure that all patients have access to the necessary health care benefits. Subsequently, the managing bodies concerned purchase health care services from hospitals and other providers for their affiliated persons. As the flow of funds from the managing bodies to the health care providers are payments for the services provided to the affiliated persons, this flow does not amount to state aid within the meaning of Article 87 EC. As result, the objective of universal coverage is achieved without violating the Treaty provisions on state aid.

Unlike the case law on the concept of undertaking, the application of the jurisdictional *Altmark* approach to health care cases is confusing and ambiguous. The Commission departs from a strict reading of the *Altmark* conditions, whereas the CFI has adopted a lenient approach. So, in EU law there is no coherent view on how to apply the *Altmark* conditions in health care cases. This lack of coherence is not in line with the point of departure formulated by the ECJ in free movement cases such as *Hartlauer*, *Apothekerkammer des Saarlandes* and *Commission v Germany*. In these cases, the ECJ argued that Member States have a considerable margin of appreciation in organising national health care as long as their national legislation attempts to realise the health care objectives that are at play in a consistent and systematic manner.⁸⁰ Unfortunately, Member States cannot be sure that financial interventions that are based on a consistent

⁷⁸ M Ross, 'A Healthy Approach to Services of General Economic Interest? The BUPA Judgment of the Court of First Instance' (2009) 34 ELRev 140.

⁷⁹ See in this respect also A Cygan, 'Public Health Care in the European Union: Still a Service of General Interest?' (2008) 57 ICLQ 555.

⁸⁰ See paras 48-71 of Case C-169/07, *Hartlauer*, 10 March 2009, n.y.r., paras 19 and 27-60 of Joined Cases C-171/07 and C-172/02, *Apothekerkammer des Saarlandes and others*, 19 May 2009, n.y.r., and paras 46-63 of Case C-141/07, *Commission v Germany* [2008] ECR I-6935.

and systematic design will be found in accordance with Articles 87-89 EC. After all, the Community rules on state aid and health care are themselves not consistent and systematic.

It is necessary that the approaches of the CFI and the Commission are reconciled. In this writer's view, a weak point in the reasoning of the CFI is that SGEI missions and PSO may be derived from general obligations laid down in national legislation. As a result, Member States may be tempted to give financial support to all kinds of health care operators without articulating the special tasks concerned. As this may distort competition, the CFI should consider formulating stricter conditions with regard to the condition of entrustment of a SGEI mission (and a PSO). Hopefully, in future judgments the ECJ will again stress the necessity of a clear and transparent entrustment of such a mission, as soon as it is confronted with a case on state aid and health care. The advantage of such a decision would be that Member States are obliged to develop an articulated state aid policy regarding SGEI/PSO and health care. After all, not all health care services amount to SGEI/PSO. National laws that merely oblige enterprises to respect certain conditions but that do not impose any duty upon them, cannot amount to the entrustment of a special task.

On its part, the Commission could consider not interpreting the fourth *Altmark* condition in a dogmatic way but taking into account the specific health care context. This would imply that as long as the national compensatory measures do not lead to offsetting costs resulting from inefficiency, the fourth *Altmark* criterion is met. Under such an approach the Member States would have more leeway in financing their health care systems - which is in line with Article 152(5) EC - whereas considerable competition distortions are not likely to occur since funding inefficient health care operators is not allowed. By stressing the point that national measures may not lead to compensation of inefficient undertakings (and by not requiring that only cost-efficient companies may benefit from these measures), the Community institutions would give room to the Member States to build in their health care schemes concerns related to the quality of the services provided to patients (apart from efficiency objectives).⁸¹ It goes without saying that such an approach would foster access for all to high quality care.

In any event, as long as the Community institutions put forward differing views as to how the concepts of SGEI and PSO should be interpreted, the compatibility of national financing health care measures (aiming at realising universal coverage) with Community law is at stake. It could be argued that Member States that have opted for a market oriented health care system are 'punished' for this choice, as they are disconcerted by the differing views put forward by the Community institutions and do not know to what extent they are allowed to make use of financial interventions. Moreover, even Member States that have not opted for such a system have to face uncertainty, since financial support given to health care providers such as hospitals falls within the ambit of Articles 87-89 EC.

⁸¹ Cf. R van den Esschert, 'Valt het risicovereveningssysteem daadwerkelijk onder de reikwijdte van het staatssteunverbod van artikel 87 lid 1 EG?', Master Thesis, Nijmegen 2009, p 86.

It is time that action is taken at EU level in order to clarify the concepts of SGEI and PSO in relation to national financial health care interventions. The Commission will evaluate its *Altmark* package.⁸² An important aspect of this review should be how to integrate the CFI's views with the Commission's opinion. It could be considered laying down a mitigated interpretation of the fourth *Altmark* condition (the requirement of the well-run company) in the revised *Altmark* package but holding on to the requirement of the explicit entrustment of a SGEI mission (or a PSO).

Additionally, Member States should consider anticipating the importance of this requirement, which implies that they must designate SGEI missions and PSO in a clear and transparent way. So, it is also time that action is taken at the Member States' level. Member States should also contribute to the development of the concepts of SGEI and PSO in health care. They have to point out which health care services their inhabitants should have access to.⁸³ National legislators should define precisely the public interests involved because the concepts of SGEI and PSO are limited to what is necessary (principle of proportionality).⁸⁴ This implies, at least in this writer's view, that national legislation must clearly specify which health care services fulfil an essential function in modern society.⁸⁵ This could entail a change in the settled practice of how health care is regulated in (some) Member States. National legislators are forced to decide in advance which health care services have to be provided in a market-oriented setting and which services must be sheltered from market-driven forces. It is inevitable that this will lead to Europeanization of some significant aspects of the national health care organisation of the Member States. After all, national legislatures should model national health laws in line with the special features of SGEI and PSO.⁸⁶ But the other side of the coin is that the Member States will remain competent to finance particular health care services without intervention on the part of the Commission.

To conclude, universal coverage is at the heart of the way the European State Aid rules deal with health care. The approaches developed at EU level take concerns related to universal coverage into account. But these approaches suffer from disease and must, therefore, be cured in order to prevent health care systems suffering from bad health.

⁸² Pursuant to Article 19 of the 2005 decision on state aid and SGEI the Commission must undertake an impact assessment with regard to the *Altmark* package by 19 December 2009 at the latest.

⁸³ Hatzopoulos points out that Community law may give rise to a shift from defining the scope of a health care system to defining health care services of general interest. See V Hatzopoulos, *op cit*, n 47, pp 241 & 251.

⁸⁴ W Sauter, 'Services of general economic interest and universal service in EU law' (2008) 33 *ELRev* 193.

⁸⁵ See JW van de Gronden and JJM Sluijs, *De betekenis van het EG-Verdrag voor het reguleren van de zorgmarkt* (The consequences of the EC Treaty for regulating health care markets), Preliminary report for the Dutch Health law Association (Vereniging voor Gezondheidsrecht), The Hague, 2009, pp 180 and 181.

⁸⁶ See also V Hatzopoulos, 'Financing National Health Care in a Transnational Environment: The Impact of the European Community Internal Market', 26(3) *Wisconsin International Law Journal* 788, (2008-2009).