Chapter 12
This Won't Hurt a Bit: The Commission's Approach to Services of General Economic Interest and State Aid to Hospitals

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Abstract The exemption regime for healthcare services that constitute SGEI as part of the 2011 Decision under the new SGEI Package has been broadened considerably to cover not just hospital care but all (curative) healthcare as well as long-term care, irrespective of the amount of aid or turnover concerned. The IRIS-H decision concerning the financing of public hospitals in the Brussels capital region of Belgium, although adopted by the Commission prior to the 2011 SGEI Package, proves a useful illustration of the way the Commission applies the rules on State aid and SGEI compensation in practice. Both the new 2011 SGEI Package and the State aid practice show that the Commission is content to do without a stringent application of the State aid rules based on economic analysis in the hospital sector—or indeed in healthcare and long-term care at large: net costs are assumed as given, and only the scope for reasonable profits is restrained. The Commission could presumably reverse this trend by bringing its own practice into line with a more ambitious interpretation of its recent legislation, and insisting that Member States do the same.

The views expressed here are personal.

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12.1 Introduction

The hospital sector in the European Union is organised on various lines, both in terms of public and private provision and in terms of the degree of solidarity or competition in respect of the sector's regulation. Hospitals can be large or small and the former are not only providers of intra- and extramural care but are also major employers and major purchasers of often complex and expensive goods and services. As with most social services in Europe, the provision of hospital services is primarily a matter of national competence,[1] subject to the Treaty rules on free movement and competition, including the State aid rules.[2]

The provision of medical services and the acquisition, and subsequent use of, complex medical devices and equipment are market activities that can have

[1] Article 168 TFEU.

[2] See also Hancher and Sauter 2012; Sauter and van de Gronden 2011, p. 615.

important spillover effects on upstream and downstream markets. It therefore follows that national funding for the hospital sector, although critical for social welfare, can also have important competition implications. This makes the practice of 'deficit funding'—that is ex post compensation for shortfalls in hospital budgets—a particularly sensitive issue.[3] The application of the EU State aid regime to this type of ex post funding is the focus of this chapter.

Following the codification of the so-called compensation approach that was pioneered in the 2003 *Altmark* case,[4] hospital financing has been recognised as an explicit candidate for a 'Services of General Economic Interest (SGEI) exemption' based on Article 106(2) TFEU, both under the original 2005 SGEI Package and again under the recently adopted second SGEI Package of 2011.[5] In this chapter we will outline both SGEI regimes for hospital services in general terms before discussing one of the few Commission State aid rulings on the merits in this field: the Commission's 2009 IRIS-H Decision concerning hospitals in the Brussels region.[6] Because this Decision is so far available only in French and in Dutch we believe a more detailed discussion in English may be useful for a broader audience.

The three main questions that we will address here are:

- What is the SGEI regime for hospital services and how has it changed between the first and second *Altmark* packages, if at all?
- How strictly does the Commission apply the *Altmark* criteria and those of the SGEI Package (block exemption Decision) to hospital services in practice?
- What lessons can be learned for national authorities assigning or entrusting SGEI concerning hospital services?

Our conclusion will briefly summarise our findings on these points.

12.2 The 2005 *Altmark* Package Decision

As is extensively discussed elsewhere in this volume the Commission adopted its first *Altmark* Package in 2005 consisting of a Decision, a Framework Communication and an amendment and codification of the Directive on financial transparency in 2006.[7] The 2005 Decision contained a block exemption both for specific

[3] See also Koenig and Paul 2010, p. 755.

[4] CJEU, Case C-280/00 *Altmark Trans GmbH and Regierungspräsidium Magdeburg v Nahverkehrsgesellschaft Altmark GmbH, and Oberbundesanwalt beim Bundesverwaltungsgericht* (Altmark) [2003] *ECR* I-7747.

[5] Sauter W 2012.

[6] European Commission, Decision of 28 October 2009, State aid measure NN 54/2009 (ex CP244/2005)—Belgium. Financing of public hospitals of the IRIS-network of the Brussels capital region. (Available in Dutch and in French only).

[7] 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

types of services without any restrictions on the amount of aid or on their turnover—including hospital services—as well as for all services provided by undertakings with an annual turnover threshold of less than € 100 million and subject to a maximum aid of € 30 million. Hence we will focus our discussion on the 2005 Decision and we will not deal at length with the other aspects of the *Altmark* Package, which are relevant to different types of services.

The Decision first sets out the types of services that may qualify for exemption and then details the conditions under which they are exempted, notably the need for an explicit act of entrustment and specification of the parameters for compensation and the mechanism for retrieving overcompensation. Services that are exempted need not be notified to the Commission nor does the otherwise standard standstill obligation apply: aid can thus be awarded immediately and lawfully without further action by the Commission. Services that may be exempted but which do not meet the conditions on the other hand are subject to notification for an individual exemption decision under the Framework, which applies substantively largely identical conditions.

Article 2(1)b of the 2005 Decision covered 'public service compensation granted to hospitals (…) carrying out activities qualified as SGEI by the Member State concerned.' The nature of the activities concerned is left to the Member States. Recital 16 stated as follows:

> Hospitals (…) which are entrusted with tasks involving services of general economic interest have specific characteristics that need to be taken into consideration. In particular, account should be taken of the fact that at the current stage of development of the internal market, the intensity of distortion of competition in those sectors is not necessarily proportionate to the level of turnover and compensation. Accordingly, hospitals providing medical care, including, where applicable, emergency services and ancillary services directly related to the main activities, notably in the field of research (…) should benefit from the exemption from notification provided for in this Decision, even if the amount of compensation they receive exceeds the thresholds laid down in this Decision, if the services performed are qualified as services of general economic interest by the Member States.

It was, therefore, not sufficient to provide hospital services: in addition it was necessary that the services concerned were designated as SGEI. The conditions that must be met were, first, that the act or acts concerned must specific (i) the nature and the duration of the public service obligations; (ii) the undertaking and territory concerned; (iii) the nature of any exclusive or special rights assigned to the undertaking; (iv) the parameters for calculating, controlling and reviewing the compensation; and (v) the arrangements for avoiding and repaying any overcompensation. Second, compensation could not amount to more than the costs of

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(Footnote 7 continued)
entrusted with the operation of services of general economic interest *OJ* 2005 L312/67; Community framework for State aid in the form of public service compensation *OJ* 2005 C297/4; Commission Directive 2006/111/EC of 16 November 2006 on the transparency of financial relations between Member States and public undertakings as well as on financial transparency within certain undertakings *OJ* 2006 L318/17.

the services concerned and a reasonable profit. A mechanism to control for overcompensation with annual checks had to be in place although a maximum of 10 % excess financing could be carried forward to a following year. In addition the Decision imposed information (records kept for 10 years) and transparency requirements with three yearly reporting to the Commission.

12.3 The 2011 SGEI Package Decision

In December 2011 the Commission comprehensively updated its SGEI Package.[8] The basic structure with block exemptions in a Decision and dealing with individual notifications under the Framework was not changed although the aid threshold in the 2011 Decision is now lowered from € 30 million to € 15 million. A change in emphasis has been that the Decision now targets social services in a much broader sense than before, leaving the Framework to deal mainly with the utilities sectors (e.g. energy, water and waste disposal services, transport and electronic communications) where the Commission expects there is more scope for liberalisation and less risk of political controversy—at least less than when exposing social services to the State aid and competition rules. This new Framework is dealt with in depth in various other chapters and we do not go into detail here nor do we provide a full critical assessment of it.

The new definition of the healthcare services covered in Articles 2(1)b and 2(1)c of the 2011 Decision is now much broader:

> (b) compensation for the provision of SGEI by hospitals providing medical care, including, where applicable, emergency services; the pursuit of ancillary activities directly related to the main activities, notably in the field of research, does not, however, prevent the application of this paragraph;
>
> (c) compensation for the provision of SGEI meeting social needs as regards health and long-term care, childcare, access to and reintegration into the labour market, social housing and the care and social inclusion of vulnerable groups;

The relevant recital (11) is substantively unchanged although in part the text is now incorporated in Article 2(1)b. The most significant extensions are obviously

[8] Commission Decision of 20.12.2011 on the application of Article 106(2) of the Treaty on the Functioning of the European Union 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* 2012 L7/3; Communication Commission European Union framework for State aid in the form of public service compensation, *OJ* 2012 C8/15; Communication from the Commission on the application of the European Union State aid rules to compensation granted for the provision of services of general economic interest Brussels, [2012] C8/4. A draft Commission Regulation on the application of Articles 107 and 108 of the Treaty on the Functioning of the European Union to *de minimis* aid granted to undertakings providing services of general economic interest was scheduled for adoption in April 2012, *OJ* 2012 C8/23 and was adopted as Regulation No 360/2012 on 25 April 2012: *OJ* 2012. L 114/8.

the unlimited inclusion of 'health and long term care' in Article 2(1)c which sits uneasily with the specifications in Article 2(1)b as regards the various types of medical services and the status of ancillary activities. Indeed it raises the question whether the more general phrasing in Article 2(1)c could not have sufficed. However, it may be that the link between health and long-term care with social needs is construed as a restriction, the scope of which is yet unclear.

The obligations in relation to the act of entrustment, its contents, the parameters for compensation based on cost plus reasonable profits, controls on overcompensation are the same as under the 2005 regime, except for the addition of a more extensive elaboration on how to determine what a reasonable profit entails. This latter is based on a rate of return on capital that takes into account the degree of risk incurred. The rate of return on capital should be defined as the internal rate of return that the undertaking obtains on its invested capital over the duration of the period of entrustment based on a benchmark of the relevant swap rate plus 100 basis points.

There is so far no experience of the application of the 2011 Decision in this sector, given that it only came into force on 31 January 2012. Instead we will take a closer look at the only substantive SGEI ruling concerning hospital services, the Commission's 2009 IRIS-H Decision.

12.4 Commission Decisions in the Hospital Sector

The Commission Decision of October 2009 concerning the financing of public hospitals in the so-called IRIS network of public hospitals in Brussels was groundbreaking (the IRIS-H Decision).[9] This is because it was, and remains, the first full Decision at EU level concerning the application of the State aid rules to the hospital sector. The Commission concluded that the Belgian measures were indeed State aid. However, in so far as these measures came into effect after November 2005, they were both exempted from notification and compatible with the internal market under Article 108(3) TFEU because they were in accordance with the formal and substantive conditions of the 2005 SGEI Decision. Moreover the Commission declared those measures which had entered into force before that date and that had not been notified to be compatible with the internal market as well, because they met the conditions of Article 106(2) TFEU. Both aspects will be discussed in detail further below.

It may be noted that the Commission had considered a system of capital allowances for hospitals in Ireland and found it to be compatible with Article 108(3) (c) TFEU.[10] In general, the Commission appears reluctant to be drawn into

[9] Above n 6.

[10] European Commission, Decision of 27 February 2002, State aid measure N 543/2001—Ireland. Capital allowances for hospitals.

detailed analysis of hospital sector aid. Notably, the Commission has rejected several complaints concerning hospital financing in various Member States,[11] or it came to the conclusion that the measure concerned did not constitute aid.[12]

In the German hospitals case *Asklepios Kliniken* (2007) a number of private hospitals had complained that German public hospitals received State aid by way of regional support—mostly in the form of unlimited guarantees.[13] The complaint asked the Commission in January 2003 to look into the allegedly unlawful conduct on the basis of the information which it had provided to the Commission and to take measures to suspend the aid until such time as the Commission had taken a final decision. The Commission initially refused to take a decision, and ultimately informed the complainants that its position on the matter was covered by the then draft Decision of 2005 on Compensation for SGEI. The complainants challenged the Commission's approach before the General Court. They argued that the Commission had used an unreasonable delay in responding to their complaint, and further that the final position taken by the Commission was not a legitimate method of dealing with their complaint.

The General Court confirmed that the general rules on legal review provided legal standing not just against decisions but against refusals to take a Decision as well. Nevertheless, the General Court dismissed the action, as the adoption by the Commission of a decision of general scope setting out abstract criteria for assessing the legality of State financing does not by itself constitute a definition of its position by the Commission on a complaint concerning that financing. Only the actual application of those criteria by the Commission to the situations complained of can constitute a definition of position that creates legal standing.[14] Finally the Court held that the reasonableness of the duration of the investigation of a State aid complaint must be determined in relation to the particular circumstances of each case, its context, the various procedural stages and the complexity of the case. Uncertainty about the (national) legal framework concerned may justify the Commission deferring its proceedings pending clarification.[15]

In the meantime, the Commission has ruled twice on the financing of health insurers in Ireland and once in The Netherlands (all three cases concerned more specifically risk equalisation systems)[16] while the General Court has handed down

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[11] CJEU, Case T-167/04 *Asklepios Kliniken GmbH v Commission* [2007] *ECR* II-2379.

[12] GC, Case T-397/03 *Fédération de l'hospitalisation privée*, *OJ* 2006, C22/25. This case was withdrawn and removed from the register.

[13] Case T-167/04 *Asklepios Kliniken GmbH v Commission* [2007] *ECR* II-2379.

[14] lbid, paras 77–78.

[15] lbid, para 81.

[16] Decision of the Commission of 13 May 2003 with regard to State aid N 46/2003—Ireland—risk equalisation scheme in the Irish health Insurance market; Decision of the Commission of 3 May 2005 with regard to State aid N 541/2004 en N 542/2004—The Netherlands—risk equalisation system and retention of reserves; Decision of the Commission of 17 June 2009 with regard to State aid N 582/2008 (IP/09/961)—Ireland—health insurance intergenerational solidarity relief.

an important ruling concerning the first Irish Decision in the *BUPA* case.[17] However, the case that we will discuss here is the first in which the Commission directly tackles the often opaque world of hospital financing.

12.5 The IRIS-H Decision

The Commission's approach in the IRIS-H Decision suggests that it opened its investigation only reluctantly. Two associations representing private hospitals in Brussels first filed a complaint in September 2005. After 3 years of discussion, the Commission effectively rejected the complaint (see below). The plaintiffs appealed to the General Court but in the meantime—and after an informal meeting convened by the General Court in July 2009—the Commission published a comprehensively motivated decision in October 2009. (The General Court had meanwhile dismissed the appeal by the plaintiffs against the earlier putative decision.[18]) As a result, after 4 years of proceedings the plaintiffs were left with a first phase State aid decision—as the Commission did not think it was necessary to open the second (contentious) phase. The plaintiffs have appealed against the Commission decision, and this appeal is now pending before the General Court.[19]

12.5.1 Background

12.5.1.1 The Beneficiaries

The IRIS-H Decision concerns the five public hospitals in the Brussels capital region jointly identified as the IRIS-H (hospitals). From 1996 onward the organisation and the operations of these five hospitals including their financing has been elaborated in plans that were decided upon by the IRIS framework body in which the five hospitals cooperate. This IRIS body is subject to public supervision and itself mainly consists of communal representatives of the public centres for social security in Brussels (which administratively is made up of 20 separate communes) alongside representatives of physicians' organisations and of the two university hospitals in Brussels.

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[17] GC, Case T-289/03 *British United Provident Association Ltd (BUPA)* et al. *v Commission* [2008] *ECR* II-81.

[18] GC, Joined Cases T-128/08 and T-241/08 *Coordination bruxelloise d'Institutions sociales et de santé (CBI) and Association bruxelloise des institutions des soins de santé privées asbl (ABISP) v Commission*, *OJ* 2010, C195/17.

[19] GC, Case T-137/10 *Coordination bruxelloise d'Institutions sociales et de santé (CBI) v Commission*, Pub 2010, C148/38.

The IRIS concept was the result of fundamental restructuring of the financing and supervision of hospitals in Belgium dating back to 1995. Briefly summarised, the Brussels' government has decided to balance the budgets of the hospitals concerned by means of a € 100 million loan extended to the IRIS hospitals via the Brussels' communes.[20]

12.5.2 Sources of Financing

The system of public financing for all hospitals in Belgium remains complex, even after the above-mentioned reforms. During the period covered by the Commission's investigation the Belgian hospitals received six different types of financing for carrying out their SGEI, as formulated at national level (discussed further below).

The relevant sources and volumes of the financing are set out in the Decision:[21]

- Sickness- and invalidity insurance payments, which cover only part of hospital costs;
- Full or partial restitution of the compensation paid to hospital doctors (the entire amount paid by patients to reimburse the interventions of medical doctors is collected centrally and redistributed);
- Operating costs through a special budget that is based on reimbursement per standard day of care provided. This also covers additional costs for hospitals that care for patients who are challenged socially and/or economically;
- Investment subsidies—intended to cover the building and (interior) remodelling of hospitals including investments in medical devices;
- An indemnity awarded for costs with regard to construction projects or closing down hospitals.

The sixth source of financing only relates to public hospitals including the IRIS-H, and constitutes additional funding by the Brussels communes that can be used to cover the budget deficits of the public hospitals.[22]

12.5.3 The Public Service Obligations

Apart from the pso which applies to all hospitals and is set out at national level in the Law on Hospitals, the IRIS-H are also subject to a supplementary pso that is formulated by the IRIS framework body itself (and thereby, by the representatives of the social services of the communes who have a majority there). This concerns

[20] As was the case on 31 December 1999, compared to a cumulative deficit of almost € 200 million on 31 December 1995, the year of the above-mentioned aid.

[21] IRIS-H Decision, above n 6, points 29–48.

[22] Ibid., points 43–48.

(i) the duty to treat everyone (also for services other than emergency services) and (ii) the duty or maintaining a full range of hospital services at every location operated by the IRIS-H.

The IRIS-H are also required to fulfil a number of non-healthcare of 'social' pso that are carried out by the IRIS framework body. These tasks are delegated to the hospitals by the public centres for social security of the relevant Brussels' communes and are financed based on agreements between the communes and the IRIS-H that regulate the grant of specific subsidies.

Finally the IRIS-H are under an obligation to ensure that a large proportion of their staff is bilingual (as the region of Brussels is both French and Dutch-speaking). This obligation is not imposed on the private hospitals in Brussels or any other hospitals in Belgium and the annual costs are estimated at € 4 million.

12.5.4 The Complaint

The plaintiffs did not contest all six of these subsidies—they only contest the subsidy for social public service obligations, the subsidy to make up for budget deficits (i.e. the sixth source of hospital funding listed above) and the one-off restructuring subsidy in 1995.

According to the plaintiffs there are no public service obligations that are specific to the IRIS-H. The only such obligations that exist are imposed by the Law on Hospitals,[23] which apply to all hospitals without distinction regarding their public or private status and regarding both emergency care and elective treatment. The complaint focuses on the fact that at federal level the system is the same for public and private hospitals whereas at local level only the deficits of public hospitals are compensated, while at regional level supplementary ad hoc subsidies are also exclusively reserved for public hospitals. The plaintiffs assert that the private hospitals are consequently forced to reduce their capacity or may even be forced to close down. By contrast, studies carried out for the Belgian government show that the costs of hospitalisation in a public hospital are € 21 per day higher than in a private hospital.[24]

[23] Loi sur les hôpitaux coordonnée du 7 août 1987 (coordinated law on hospitals of 7 August 1987), Moniteur Belge (Belgian offical journal) 7 October 1987, in force from 17 October 1987.

[24] According to a report by the Belgian Mutualités Chretiennes discusssed by Lienard 2004, p. 10 (with statistical annexes). This was the difference between a hospital day in public (€ 258) and private hospitals (€ 237) in 2003.

12.6 The Evaluation by the Commission

Because the original complaint dated back to October 2005—and as according to Article 15 of Regulation 659/1999[25] the competence of the Commission to recover aid expires after 10 years—the fact that the original restructuring took place in 1995 is significant. The limitation on recovery does not however affect the powers of investigation of the Commission, and as such the Decision focuses on the aid granted from October 1996 onward, but including the aid that was granted in the restructuring of 1995.

The Commission considered it necessary to investigate all the sources of financing that the IRIS-H received by way of pso compensation (i.e. for intramural and extramural care and including social services) in view of the requirements set out in the *Deutsche Post* Case,[26] where the General Court has ruled that the Commission is required to carry out a comprehensive and thorough investigation in order to establish whether the total amount of aid by way of compensation of a SGEI was not in excess of the net costs of providing the services concerned.

The Commission's approach was to investigate first whether the funding at issue constituted State aid in the sense of Article 107(1) TFEU before addressing the defence of the Belgian state that was based on the *Altmark* case.[27] The Commission investigated in turn whether (i) undertakings were involved in (ii) a transfer of state resources that (iii) conferred a selective advantage on them (iv) to the detriment of trade between the Member States.

12.6.1 The Concept of Undertaking

The Belgian authorities adopted the position that the hospitals were not involved in economic activities as they were fully based on the solidarity principle.

The Commission found that in view of established case law,[28] the economic nature of the hospitals' activities was without doubt. The main activities of the IRIS-H, which consist of elective and emergency medical care (intramural care), are activities that were also carried out by other institutions including private hospitals. This confirms that although the solidarity aspect plays a role in the

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[25] Council Regulation (EC) No 659/1999 of 22 March 1999 laying down detailed rules for the application of Article 93 of the EC Treaty, *OJ* 1999, L83/1.

[26] CJEU, Case T-266/02 *Deutsche Post v Commission* [2008] *ECR* II-1233.

[27] CJEU, Case C-280/00 *Altmark Trans* above n 4.

[28] CJEU, Case C-237/04 *Enirisorse SpA v Sotacarbo SpA* [2006] *ECR* I-2843; CJEU, Case C-41/90 *Klaus Höfner and Fritz Elser v Macrotron GmbH* [1991] *ECR* I-1979; CJEU, Joined Cases C-180/98—C-184/98 *Pavel Pavlov* et al. *v Stichting Pensioenfonds Medische Specialisten* [2000] *ECR* I-6451.

Commission's assessment it is not decisive,[29] especially where private hospitals are providing the same type of intramural care (even if this is possibly not identical).

The Commission did not consider it necessary to engage in a further analysis whether the extramural activities of a social nature constituted economic activities or not because it considered that the subsidies involved would in any event qualify as aid that was compatible with the internal market.[30]

12.6.2 State Resources

As the measures concerned and their financing (at federal as well as regional and local level) originate with the responsible public authorities the Commission ruled that it was not contestable that they could be attributed to the State.

12.6.3 Selectivity

Regarding intramural care the Commission considered the measures to be selective because only the IRIS-H had been charged with the relevant pso—and also they were the only undertakings receiving compensation for these obligations. Other healthcare providers were excluded from this scheme. The Commission did not deal with the question whether this was a case of economic advantage or, as was claimed by the Belgian authorities based on the *Altmark* case,[31] purely a matter of compensation for pso. This point was dealt with separately after the assessment of the other elements of State aid had been completed.

12.6.4 An Effect on Trade Between the Member States

As regards this point the Commission pointed out that several undertakings are present on the market and the position of the undertakings that benefited from the contested measures was strengthened so the existence of a negative effect on trade could not be excluded. Moreover it pointed out there was some limited cross-border provision of services to patients for both intramural and extramural care.

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[29] CJEU, Case C-244/94 *Fédération française des sociétés d'assurances* et al. [1995] *ECR* I-4013.

[30] IRIS-H Decision, above n 6, point 111. This is remarkable because it would appear that market entry by means of public procurement would be a private alternative to the IRIS-H network.

[31] CJEU, Case C-280/00 *Altmark Trans*, above n 4.

Hence the Commission concluded that the contested financing constituted State aid in the meaning of Article 107(1) TFEU. Next it addressed the application of the *Altmark* criteria.

12.6.5 The Altmark Criteria: State Aid or Compensation?

The well-known four cumulative *Altmark* criteria can be summarised as follows:

- being charged with a clearly defined pso
- objective and transparent parameters for compensation;
- no overcompensation;
- compensation based on public procurement procedure or the costs of an efficient undertaking

Based on the 2008 *BUPA* case the rule is that these *Altmark* criteria must be applied ex tunc,[32] i.e. retroactively to the IRIS-H subsidies that were granted before the *Altmark* ruling took place, as the CJEU had chosen not to limit the applicability of its *Altmark* judgment in time. The Commission next tried to simplify the analysis by considering only two of the four *Altmark* criteria, and went on:

- first, to analyse whether the undertakings involved had indeed been entrusted with an SGEI (the first criterion);
- and second whether the selection of the undertakings involved had been based on the fourth criterion

12.6.6 Entrustment

The Commission recalled the broad discretion enjoyed by the Member States in this sector—as had been confirmed in the *BUPA* case:[33]—the organisation of the healthcare sector largely remains the domain of the Member States. The role of the Commission is limited to checking for a manifest error of judgment.

As regards intramural care the Commission considered that the EU law requirements had been met. The federal system with regard to the SGEI had been well defined in the Law on Hospitals and in particular their obligatory and social character was clear. Regarding the specific pso of the IRIS-H the Commission established that these had been imposed on the basis of a law on social security services[34] and in the strategic IRIS plans that were set out by the IRIS framework

[32] GC, Case T-289/03 *BUPA*, above n 17.

[33] Ibid., para 165.

[34] Loi organique des Centres Publics d'Action Sociale du 8 juillet 1976 (Organic law on the public centres for social security), Belgian official journal 5 August 1976.

body (and 'which should be regarded as equivalent to the act of a public authority'). The IRIS-H are under the obligation to provide all types of hospital care to everyone on demand in a framework in which all types of hospital care must be available at all locations. In contrast to the private hospitals which are free to select their patients and to organise their activities the IRIS-H do not have any choice as regards the definition and the scope of the said obligations.[35] This means that the existence of a pso has been established: the territorial limitation of the users/beneficiaries involved does not affect this conclusion.[36]

As regards the non-hospital tasks of the IRIS-H (social care, alongside medical care to patients) the obligatory character of these social tasks likewise has a legal basis and can also be found in the fact that those charged with these tasks have no room for manoeuvre with regard to its definition and scope. In what appears to be circular reasoning, the social character of these tasks flows from the fact that the additional costs that are incurred by the IRIS-H to fulfil these tasks are charged to the public authorities in the context of their responsibility for setting social policy.

The first *Altmark* criterion was therefore met both for intra- and extramural care as well as the social services concerned.

12.6.7 Public Procurement or Efficient Undertaking

The Commission first established for all intramural and extramural SGEI with which the IRIS-H had been entrusted that these had not been attributed on the basis of a public procurement procedure (and noted this aspect might become the subject of separate proceedings under the enforcement of the public procurement rules).[37] In addition, neither the Belgian State nor the plaintiffs had provided sufficient evidence to determine whether the compensation mechanisms for intramural and extramural care provided by the IRIS-H actually and fully met the requirement of matching an efficient undertaking in the sense of the fourth *Altmark* criterion:

> According to the Commission it is not possible, based on the arguments provided by the parties, to establish with absolute certainty whether when setting the level of the necessary compensation, the actual costs of an average undertaking with the characteristics demanded by the case law were really taken into account and whether the IRIS-H and the private hospitals that have filed the complaint are actually such representative or average well run undertakings as the *Altmark* Case requires.[38]

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[35] 'The obligatory nature of the service and therefore the existence of a service of general economic interest are proven if the service providers is obliged to conclude agreements on fixed terms.' IRIS-H Decision, para 149.

[36] GC, Case T-289/03 *BUPA*, above n 17, para 186.

[37] Directive 2004/18/EC of the European Parliament and of the Council of 31 March 2004 on the coordination of procedures for the award of public works contracts, public supply contracts and public service contracts, *OJ* 2004 L134/114.

[38] IRIS-H Decision, above n 5, para 161.

Moreover, according to the Commission compensation for providing an SGEI that is awarded to several undertakings and that is based on their average costs without requiring any evidence of sound management would inevitably lead to overcompensation. Note that at a later stage of the decision the Commission would adopt the opposite point of view: compensation based on average costs can lead to under-compensation.) Hence the Commission held that the fourth *Altmark* condition had not been met so that the measures constituted State aid in the sense of Article 107(1) TFEU on the basis of the *Altmark* analysis. It was therefore stricter in its approach on this count in *IRIS-H* than the General Court had been in *BUPA*—where it held that the fourth *Altmark* condition could not be applied because in the system of risk equalisation the beneficiaries could not be identified in advance and compared with an efficient operator, but the requisite standard was nevertheless held to be met because the Commission had otherwise tested for inefficiencies. This brought the Commission to the third and final branch of its analysis: the question whether the contested measures were compatible with the internal market based on Article 106(2) TFEU. This required it to apply the criteria set out in the 2005 SGEI Package (cast as a specification of the general requirements of necessity and proportionality that apply under Article 106(2) TFEU).

12.6.8 Services of General Economic Interest

Article 106(2) TEFU can only be relied upon if the measure concerned respects the requirements of necessity and proportionality as well as the following conditions:

> (i) the services in question must be an SGEI that is clearly defined as such by the Member State; (ii) the undertaking provided the SGEI must have been formally charged with doing so by the Member State; (iii) application of the competition rules set out in the Treaty must obstruct the fulfilment by the undertaking of the special tasks with which it has been charged and an exemption from these rules may not affect trade to an extent that this is at odds with the Community interest.[39]

Because of the repetitive nature and the overlap of the criteria deployed as part of the various tests at both the procedural and substantive stages in this case (and similar cases) it is at times difficult to keep sight of the larger picture. The main substantive difference between the SGEI test in Article 106(2) TFEU as elaborated in the 2005 Decision and the *Altmark* criteria is that the fourth *Altmark* criterion (tender or efficiency test) is not included in the criteria of the SGEI package. In addition, there is an important procedural difference: the SGEI package and its more detailed substantive assessment criteria that elaborate on Article 106(2) TFEU only applied from November (the Framework) respectively December (the Decision) of 2005 whereas, as mentioned, the *Altmark* Case applies *ex tunc*.[40]

We shall address first the Commission's test of necessity and proportionality.

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[39] Ibid., para 165.

[40] Cf. Grespan 2008, 4.1140ff.

12.6.9 Necessity

As the General Court had already indicated in the *BUPA* Case the Member State enjoys a broad margin of appreciation not just with regard to the definition of an SGEI but also when determining the compensation of the costs involved.[41] The authorities must specify the parameters of the compensation involved so the Commission may determine whether the compensation awarded is in line with what is necessary. This is a marginal standard of review: the act of assignment must contain the necessary basic elements that enable the future compensation to be calculated. However the Member States retain the freedom to set the parameters of their choice.

The first part of the necessity criterion regarding the definition of and the entrustment of the SGEI obligations largely covers the same ground as the first *Altmark* criterion. The Commission also pointed out that based on consistent case law the fact that parts of the entrustment are found in different legal acts and/or have to be derived from the legal context does not raise any doubts as to whether these criteria (an act of assignment specifying the SGEI etc.) are met. This may be in line with the recent practice but it is perhaps surprising if we look at the list of elements that are set out in the SGEI package which must be covered by a 'clear' act of assignment.

It is less surprising that the Commission subsequently reaches the conclusion that the legal basis for compensation of the IRIS-H by the responsible authorities is clearly set out in law and regulation. As regards the compensation of deficits as a result of public service obligations that have exclusively been imposed upon public hospitals (including the IRIS-H) the Commission notes that the Law on Hospitals clearly sets out the criteria for compensation in advance and also sets out specific provisions for the compensation of SGEI-related deficits of the public hospitals. This compensation is not based on actual costs but on the average costs of a group of comparable hospitals.

Next the Commission, without any further reference to a significant investigation into the costs involved, concludes that this system can lead to undercompensation. Consequently the compensation is regarded as necessary and not just in order to compensate for the actual costs of carrying out the pso set out in the Law on hospitals. The 'ex post' compensation of deficits is also considered to be necessary from a health perspective and for social reasons in order to guarantee the continuity and the viability of the system that in all probability could not function if only a limited number of private hospitals were available.[42] It would seem that from this perspective there can never be overcompensation. What makes this observation questionable is the fact that earlier in the same decision the same compensation based on average costs was interpreted as proof that overcompensation was possible, and hence the fourth *Altmark* condition was not met.

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[41] GC, Case T-289/03 *BUPA*, above n 16, para 214.

[42] IRIS-H Decision, above n 4, para 177.

As regards the social tasks the Commission concluded, based on a succinct analysis, that here the cost parameters can likewise be determined in advance.

The Commission then tackles the question whether the provisions to prevent and/or correct for overcompensation are adequate. As regards the compensation for deficits due to pso of the public hospitals awarded by the national (federal) government the Commission concludes that this compensation is limited to the balance of the net costs of the relevant public services. Hence the compensation remains within the limits of the 2005 SGEI package: 100 % of the net costs plus a reasonable profit margin. The regional restructuring aid that had been provided by the Brussels capital region related to pso that had already been fulfilled and in accordance with parameters for compensation that were adequately defined. In addition, the region only provides temporary credits while awaiting the calculation and payment (10 years later) of the definitive deficit with regard to the public service obligations by the federal authorities. Finally the cost for the public service obligations and social tasks that are delegated by the public centres for social security via the IRIS-Z framework body are not reimbursed automatically but only when (unspecified) further demands set by the public centres for social security are met, which are designed to avoid overcompensation.

Hence the Commission concluded that these measures are adequate to meet the first compatibility criterion in the SGEI package; necessity.

12.6.10 Proportionality

Here too the Commission cites the *BUPA* case:

> As regards, more particularly, review of the proportionality of the compensation for discharging an SGEI mission, as established by an act of general application, it has further been specified in the case law that that review is limited to ascertaining whether the compensation provided for is necessary in order for the SGEI in question to be capable of being performed in economically acceptable conditions (…), or whether, on the other hand, the measure in question is manifestly inappropriate by reference to the objective pursued (…).[43]

The Commission also applies the provisions of the SGEI package and recalls that for purposes of substantive compatibility assessment (in contrast to the *Altmark* procedural test) the amount of compensation does not have to be established by means of a comparison of the costs of an efficient undertaking. If the state shows that the amount of compensation is equal to the projected net costs based on the parameters that are clearly defined in the act of assignment there will be no finding of overcompensation and the compensation involved will be regarded as compatible aid. In other words: the public authorities may compensate the

[43] GC, Case T-289/03 *BUPA*, above note 17, para 222. Most likely the GC only intended to juxtapose the necessity and the proportionality test in order to highlight that the latter test is whether the means used are manifestly inappropriate.

undertaking that has been charged with carrying out an SGEI for 100 per cent of the costs involved plus a reasonable profit margin, and ignore any consideration of efficiency in respect of how these costs are incurred. Based on its investigation of the annual accounts of the IRIS-H (i.e. the results regarding hospital services and social services, excluding non-SGEI activities) the Commission reached its conclusion that no overcompensation was involved.

This point is all the more important to the extent that the test to which the financing is subjected is less strict: this means more financial room for manoeuvre is left that could be (ab) used for cross subsidies for competitive services. The Belgian state had provided information demonstrating that the EU requirement of separate accounts had been met and this provided evidence that the division between the economic and the non-economic activities of the hospitals had been respected. The Commission considered this satisfactory. Hence the measures involved were considered not to be manifestly inappropriate, and therefore proportional.

12.7 Some Implications of the IRIS-H Decision

12.7.1 The Application of the Altmark Criteria

The Commission appears to use the approach of applying only two of the four (cumulative) *Altmark* criteria more frequently.[44] Nevertheless the question arises why the Commission has decided not to use the second (clear parameters for compensation) and/or the third (no overcompensation) criteria. Apparently, this served to simplify the analysis. The nature of the complaint may also have been decisive: the plaintiffs' position is that the IRIS-H has not been charged with distinctive pso. In addition, they are claiming that the way in which the services concerned are financed is inefficient. Perhaps the Commission did not wish to tackle the same issue twice? In addition the plaintiffs claim that even if the intervention at federal level is organised in such a way that it is compatible with the second *Altmark* criterion, the same does not apply to the regional and local levels of intervention where the system is not transparent. Because the deficits at local and regional levels are financed ex post this would mean that the system as a whole does not meet the second criterion (otherwise the second and third criteria would become indistinct—i.e. no overcompensation). Hence the plaintiffs in their appeal claim that the Commission has not applied the criteria for evaluating overcompensation properly and that transparency is also lacking.

At the same time, as we have seen, the Commission does not follow the approach taken by the General Court in the *BUPA* Case either, where it watered

[44] The Commission examined all four criteria in its Decision of 17 June 2009, State aid No N 582/2008—Ireland. Health Insurance intergenerational solidarity relief.

down the *Altmark* criteria to a considerable degree. The approach by the Commission which seems laudable leads to the finding of aid in the sense of Article 107(1) TFEU that takes place because the fourth *Altmark* criterion is not met.

12.7.2 The Application of Article 106(2) TFEU and the SGEI Package

The criteria of the 2005 SGEI Package with regard to the act of assignment are disregarded by erroneously assuming that these had been met when applying the *Altmark* test. There is no clear legal basis for the additional services that the Commission assumes must be performed exclusively by the public hospitals, while the requirement of such a basis does exist. The general pso at national level is moreover not set out in line with the requirements of the SGEI package (which may explain why *Altmark* is relied upon at this point).

In addition, there is an important distinction between the application of the *Altmark* criteria and the application of the SGEI Package: *Altmark* serves to decide whether an economic advantage was enjoyed in the sense of Article 107(1) TFEU whereas Article 106(2) TFEU is about balancing interests. This means that when carrying out the latter test the Commission omits several of the *Altmark* criteria (especially the fourth criterion) on public procurement and efficiency. This is in line with the 2005 SGEI Package, based on Article 106(2) TFEU and adopted in line with Article 106(3) TFEU. Only the first three *Altmark* criteria are repeated, with additional tests regarding overcompensation. Is this the correct approach?[45]

The efficiency test is replaced by a test in the 2005 SGEI Package that allows full compensation of costs without any considerations of value for money. It is clear that this is undesirable from a perspective of competition. The instruments of the Commission are thereby limited to checking the financing mechanisms for overcompensation (i.e. where more than actual costs incurred plus a reasonable profit) and competitors cannot compete for the market based on public procurement. This gives the providers of SGEI perverse incentives to run up costs and releases the Member States form the obligation of replacing inefficient incumbents and controlling costs. It will also not help to lower State aid levels in line with the 2005 State aid action plan.[46]

In the IRIS-H Decision the total amount of compensation for SGEI has become a crucial component of the balancing of interests when Article 106(2) TFEU is applied to establish the compatibility of the aid: the Commission does not consider the underlying costs in any detail at all. Nevertheless, this is the crucial element of this Decision which, after all, is about ex post financing of deficits. Perhaps,

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[45] GC, Case T-289/03 *BUPA* (above n 17), also assumes overlap. Cf. GC, Case T-8/06 *FAB Fernsehen aus Berlin GmbH v Commission* [2009] *ECR* II-196, paras 64 and 65–69.

[46] COM (2005) 107 final of 7 June 2005.

therefore, the relevant question is not whether the efficiency criterion has been met but what method is used to ensure that only actual costs are reimbursed. As one of us has argued elsewhere however, this is a different test.[47]

Arguably, it is not up to the Commission to develop its own standard of efficiency in the hospital sector, and even if it could take a more stringent approach to inputs it is highly questionable whether it has the power to determine outputs—the quality of service is determined by the Member States.[48] Nevertheless, it could have taken the costs in the private sector as a benchmark in order to determine whether the public hospitals were obliged to incur additional expenses in order to be able to deliver additional services. The Commission avoids using this model by claiming that the public and private hospitals have different tasks, but it is not clear from its analysis whether this distinction is wholly justified.

The plaintiffs moreover rightly point out that Article 106(2) TFEU must, because it is an exception, be interpreted restrictively and therefore (arguably, we believe) in line with the proportionality test in this provision an efficiency test is required. At a minimum the Commission could have addressed this element of the complaint.

12.7.3 Recent Developments

The 2010 Monti Report on the internal market[49] saw possibilities for establishing SGEI at EU level for specific services i.e. bank accounts (current accounts) and access to broadband services. It also pleaded in favour of aligning public procurement and the rules on SGEI and, as such, in favour of applying the fourth *Altmark* criterion more rigorously. A greater emphasis on compliance with the EU public procurement regime has been adopted with the 2011 SGEI Package, albeit that in the context of the block exemption Decision the Commission recalls that the procurement principles deriving from the Treaty free movement principles should be respected. An important innovation of the new framework which applies to aid which would not fall within the scope of the exemption Decision, is the requirement for Member States to hold a public consultation to establish public service needs.[50]

State aid to the hospital sector is unlikely to be evaluated under the new framework as this will be primarily applicable to aid measures above the EUR 15 million

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[47] Cf. Hancher and Larouche 2010.

[48] GC, Case T-442/03 *SIC—Sociedade Independente de Comunicação, SA v Commission* [2008] *ECR* 1161, at para 212.

[49] A new strategy for the single market: at the service of Europe's economy and society. Report to the President of the European Commission, José Manuel Barroso, by Mario Monti, 9 May 2010 (especially point 3.3. Social services and the single market.

[50] Commission Communication, European Union framework for State aid in the form of public service compensation, C (2011) 9406 final.

threshold. As explained, this threshold does not apply to the hospital sector. If a measure cannot be brought under the conditions set out in the Decision then it is unlikely that it could be declared compatible with the Framework, following notification, given that the latter imposes similar and indeed stricter conditions for assessing the compatibility of the aid. This leaves open the question of whether the Commission would nevertheless consider a justification based on Article 106(2) TFEU, for example where there are perhaps only weak provisions for controlling compensation levels ex ante, but where ex post controls can be satisfactorily applied.

Finally, in the Communication published along with the new 2011 Decision and Framework, the Commission considers that contracts for the performance of SGEI should be awarded in compliance with the procurement principles, as well as the EU procurement Directives in so far as these apply.[51] If adequate procedures have not been followed, then the aid cannot be deemed compatible. If in its subsequent enforcement of the new 2011 *Altmark* Package, the Commission succeeds in its attempt to restrict 'gold plating' of public services by the Member States, this may indicate that the Commission is prepared to embark on a more economic approach to examining the trade off between national public interests on the one hand and competition and free movement objectives on the other.

12.7.4 Procurement

At the time of writing the Commission has proposed a fundamental revision of the procurement regime which would provide an exemption for social services. On the same date as the Second *Altmark* package was adopted, the Commission announced its proposed reforms to the EU procurement regime.[52]

The new proposals can be summarised as follows:

- First, the Commission intends to publish a separate measure for a directive on public services concessions—albeit that social service concessions will be given special treatment.
- Second, a new 'light regime' approach to social services, including healthcare services will be introduced in the revised procurement Directive.
- Third, a new, clearer definition of contracting entity is to be adopted and the definition of the term 'bodies governed by public law' is clarified.
- Fourth, new criteria for the award of contracts will be recognised—so that a cost-effectiveness approach is firmly recognised.
- Fifth, the right of contracting authorities to deploy a strategic use of the procurement rules, for example, to improve public health will be explicitly acknowledged.
- Finally the proposal recommends the establishment of a designated national authority to monitor and review observance of procedures.

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[51] Above n 8.

[52] http://ec.europa.eu/internal_market/publicprocurement/modernising_rules/reform_proposals_en.htm

If adopted this reform will mean that a new separate procurement regime for social services, including health services is to be introduced. The Commission considers that social, health and education services have specific characteristics which make them inappropriate for the regular procedures for the award of public service contracts. These services are considered to be typically provided within a specific context that varies widely between Member States due to different administrative organisational and cultural circumstances. Therefore, once again the Commission confirms that such services have, by their very nature, only a very limited cross-border dimension. Member States should have the discretion to organise the choice of service providers.

The proposed Directive provides:

(i) a higher threshold for social services of EUR 500,000, and
(ii) that above this threshold, the only procedural obligations that will apply are the so-called procurement principles, that is, respect for the basic 'procurement principles' of transparency and equal treatment.

12.8 Conclusion

The exemption regime for healthcare services that constitute SGEI as part of the 2011 Decision under the new SGEI Package has been broadened considerably to cover not just hospital care but all (curative) healthcare as well as long-term care, irrespective of the amount of aid or turnover concerned. As before, this exemption applies to the notification and standstill requirements but only if the conditions set out in the Decision with respect to the act of entrustment, the parameters for compensation and the controls of overcompensation are met. These latter conditions are equally applicable to all sectors, albeit the Commission appears to recognise the need for some flexibility at national level.

The IRIS-H decision proves a useful illustration of the way the Commission applies the rules on State aid and SGEI compensation in practice. The first *Altmark* case and SGEI Package criterion was once again not strictly applied: instead the Commission assumed that at least a local level, public service obligations existed and had been well-defined in the regulatory context. In addition we have seen how, the fourth *Altmark* criterion on efficiency which is applied to determine whether aid is present was trumped by the more relaxed compatibility assessment standards set out in the 2005 SGEI package where no comparable criterion exists: net costs are assumed as given, and only the scope for reasonable profits is restrained.

This may well be in line with the way the SGEI Package (2005 and 2011 versions) works, but it results in a system that perpetuates the existence of perverse incentives for SGEI incumbents which both frustrate competition in the sector and in all likelihood could lead to a suboptimal provision of the SGEI themselves. The Commission also missed a golden opportunity to apply an efficiency test where in the present case it could have had comparable data for public and private hospitals at its disposal which are, after all, subject to largely comparable regulatory requirements.

It is striking that in the Brussels hospital Decision the Commission did not carry out a detailed cost/benefit analysis even where this would be possible based on national rules. It is worrying that the fact deficits are compensated by definition is justified as evidence of the solidarity-based character of the tasks involved. If all deficits are covered *ex post* the difference between the second *Altmark* criterion (setting out parameters in advance) and the third *Altmark* criterion (no overcompensation) disappears. But, as the Court held in *BUPA*, the Member State should not fund inefficiencies and to ensure that this does not occur, this ought to require an economic analysis as part of the compatibility assessment. If the Commission decision in the IRIS hospitals case is to be deemed the standard approach, this seems to suggest that we are unlikely to see a strict discipline for public service obligations in the hospital sector in the near future.[53]

This result seems to be due to an overly cautious approach by the Commission which considers all but the grossest violations of EU law out of bounds to intervention, especially in areas such as healthcare where the EU so far lacks extensive involvement (but may have ambitions to become more involved—such as is evidenced by the 2011 Patients' Rights Directive).[54] One possible way out might be stricter application of the public procurement rules in the SGEI context.[55] For the time being, however, both the new 2011 SGEI Package and the State aid practice show that the Commission is content to do without a stringent application of the State aid rules based on economic analysis in the hospital sector—or indeed in healthcare and long-term care at large.

The lesson for the Member States is likely to be that they can remain relatively relaxed about formal SGEI entrustment of hospital services as the Commission is likely to derive public service obligations from the general regulatory context as necessary. This is relevant for Member States as it shelters them from making tough decisions on access, priorities and preferential funding. This is regrettable because apart from foregoing the salutary effects of Member States making precisely those choices explicit, this approach also curtails the possibility for third parties to point out discrepancies and contest the coherence and thereby the validity of formal SGEI entrustment—or the lack thereof. In terms of legal certainty and legal protection this is a lamentable result, even if it is one the Commission could presumably reverse, by bringing its own practice into line with its recent legislation and insisting that Member States do the same. The coming into force of the 2011 SGEI Package would be an excellent moment to start doing so.

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[53] However, see Commission Decision 2006/513/EC of 9 November 2005 on the State Aid which the Federal Republic of Germany has implemented for the introduction of digital terrestrial television (DVB-T) in Berlin-Brandenburg, *OJ* 2006, L200/14, confirmed in GC, Case T-8/06 *FAB Fernsehen*, above n 46, paras 63ff.

[54] Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare, *OJ* 2011, L88/45.

[55] Cf. Office of Fair Trading (OFT) (2010) http://www.oft.gov.uk/shared_oft/economic_research/oft1242.pdf (last accessed 15 May 2012); J. Fingleton, Reforming public services, speech of 7 July 2010. http://www.oft.gov.uk/shared_oft/speeches/689752/0810.pdf (last accessed 15 May 2012).

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