Master Thesis

Services of General Economic Interest within the Dutch healthcare system

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INTRODUCTION

So far, the relevance of EU competition and state aid law in the Dutch healthcare sector has not been a much debated subject. However, the liberalization process of this sector is ongoing ever since the market-oriented healthcare reform of 2005/2006 that has introduced a regime grounded on competing private health insurers and private healthcare providers. Consequently, the impact of EU competition rules on this sector have increased, with regard to their relevance for this liberalization process (create new markets for private competition, in order to improve quality and efficiency). This increased impact could as well be declared by the extended interpretation of the notion of ‘undertaking’ during the years, which has a crucial role within the application of EU competition -and state aid rules. Furthermore, since EU competition and state aid law has direct effect (recognized and enforced by national courts), it affects the national healthcare system which originally could be seen as a national matter based on article 168(7) TFEU as well.

Notably, the interface between EU state aid law in particular and the healthcare sector appears to be politically sensitive from a public policy perspective. As already mentioned, the organization and delivery of healthcare is reserved at national level under article 168(7) TFEU. However, within the EU state aid regime the European Commission (EC) has the exclusive power to decide on compatible state aid. Concerning these conflicting powers, the impact of EU state aid law on the national healthcare system and the national public policy will therefore be an interesting field of research and will be examined in the first chapter.

So far, within the leading state aid cases in healthcare the focus has been on the Services of General Economic Interest (SGEI) instrument. Generally, financial support granted by public authorities is prohibited under article 107(1) TFEU as state aid will harm both market access and market structure. However, restrictions on competition within the market could be accepted if the state aid concerns compensation of public service task under the heading of a SGEI. Article 106(2) TFEU, which includes this SGEI instrument, might be a useful exception to the EU state aid rules. Notably, the designation of SGEI is confirmed to be a national task. Consequently, Member States have much flexibility to decide whether compensation of SGEI granted by public authorities could be exempted from the state aid prohibition under article 107(1) TFEU for the purpose of the public interest. Especially important for the application of

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the SGEI concept has been the Altmark Package (2005)\(^5\), recently updated in December 2011\(^6\). This so-called ‘Altmark Package Mark II’ entered into force on 31 January 2012\(^7\).

The SGEI instrument is intended to find a balance between the public interest and the EU state aid rules. However, the application of SGEI must comply with the proportionality test, which aims to restrict these exceptions\(^8\). Before we will discuss the impact of the SGEI exception on the healthcare sector, it is useful to recap some of the fundamentals. Therefore, we will outline the EU state aid rules on the application of SGEI in chapter two. More specific questions with regard to healthcare are formulated in the third chapter.

Having looked at the more general aspects of the SGEI concept and its impact on healthcare, the focus of this research will be on the Dutch healthcare policy in chapter four. Notably, the Dutch healthcare system is basically market-driven, which means that it exclusively includes private healthcare insurers and private healthcare providers. Since the health insurance reform and price liberalization in 2006, discussions on deregulation and liberalization of the healthcare sector have been ongoing. Generally, financial support for undertakings by public authorities is undesirable within this liberalization process, as this distorts competition on the market. However, as we will see not all healthcare services could be provided appropriately within a competitive market and should, in order to guarantee their availability, receive compensation of public service obligations by public funds. Consequently, the SGEI exception on the state aid prohibition under article 107(1) TFEU seems to have a significant role within the healthcare sector.

Within the Dutch healthcare policy, the use of the SGEI instrument is developing. Recently, the Dutch Ministry of Health, Welfare and Sport has adopted the Decision availability contribution WMG (Healthcare Regulation act)\(^9\). The aim of the included availability contribution is to compensate healthcare providers for the costs related to an imposed public service obligation based on the SGEI exception under EU state aid law. By now, developments with regard to this brand-new instrument are ongoing, in order to designate certain healthcare services that should be compensated by public resources to guarantee their availability. As an independent regulator of the healthcare market, the Dutch Healthcare authority (NZa) is responsible for the attribution of state aid within this sector.

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\(^5\) 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 (PbEU 2005, L31 2/67)

\(^6\) Commission Decision of 20 December 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 (PbEU 2012, OJ L7/3)

\(^7\) European Commission, Press release, State aid: Commission adopts new rules on services of general economic interest (SGEI), 20, IP/11/1571 December 2011.


\(^9\) Besluit van 24 augustus 2012, houdende aanwijzing van de vormen van zorg die in aanmerking kunnen komen voor een beschikbaarheidsbijdrage op grond van de Wet marktordening gezondheidszorg en enkele wijzigingen in het Besluit uitbreiding en beperking werkingssfeer WMG (Besluit beschikbaarheidsbijdrage WMG), jaargang 2012 396.
This Master thesis is based on a theoretical research in combination with experiences gained from my internship at the Dutch Healthcare authority.

The focus of this study will be on the role of the SGEI concept within the EU state aid regime. In this sense, we will discuss the impact of this exception from EU competition and state aid law on the healthcare sector. Special attention goes to the role of SGEI with regard to the healthcare system in the Netherlands where this instrument could be applied under national competition law. Developments concerning the indication and the value of the availability contribution within the Dutch healthcare system will be discussed, in comparison with the EU policy on SGEI.

We will examine the following sets of issues:

- The impact of EU state aid law on the healthcare sector;
- The role of SGEI within EU state aid law;
- The impact of the SGEI-exception on the healthcare sector;
- The role of the SGEI within the Dutch healthcare system;

During the four chapters of this Master thesis we will draw some first conclusions. The final objective of this research is to define the impact of the EU state aid rules on the application of the SGEI exception within the Dutch healthcare sector. Therefore my research will be concluded with an answer to the following central question:

What is the impact of the application of European State Aid rules on the healthcare sector and what is the actual effect of the Services of General Economic Interest exception on the Dutch healthcare system?
CHAPTER 1 LEGAL FRAMEWORK ON EU STATE AID LAW

"Competition policy must help to guarantee accessible and affordable high-quality public services, which are fundamental to citizens' well-being and quality of life and which also contribute to social and territorial cohesion." (Competition Commissioner Joaquin Almunia, February 2010)

Regarding the citation above, Joaquin Almunias’ vision of competition policy seems to be in line with the more general objective of Europe; the accomplishment of an area of peace and stability, freedom and democracy. Combined with the euro and the internal market, competition policy aims for the progression of the well-being of the EU citizens on the basis of efficiency and fairness. Against this background, the link between competition law and the organization of healthcare provision has been frequently discussed. Member States have been instructed to apply article 101 and 102 of the Treaty of the Functioning of the European Union (FTEU) since the modernization of competition law in May 2004, which indicates a certain degree of decentralization. These provisions prevent the restriction of competition (article 101 TFEU) and the abuse of a dominant position (article 102 TFEU) by undertakings. These articles are the fundamentals within the ‘classic’ competition law, which includes rules on anticompetitive agreements merger control and dominance abuse. These elements will not be the focus of this thesis, which instead involves EU state aid law. Unlike the decentralized system with regard to the more general competition rules, only the Commission can declare whether state aid is compatible with the internal market or not. This makes state aid law a rather centralized area. However the EU state aid rules are directly applicable within the national framework. Article 107(1) TFEU covers the prohibition of any form of advantages to undertakings granted by national public authorities. Nevertheless, the Treaty emphasizes the necessity (and therefore compatibility) of state intervention in some circumstances in order to underwrite a well-functioning economy.

Over the past years, the impact of EU competition rules with regard to healthcare has been increased. Notably, the organization of healthcare is highly divergent between the Member States, which could be problematic with regard to highly centralized system of state aid control (the European Commission has a significant role within the investigation of state aid under article 107(1) TFEU, which will be discussed in a further stage of this research). The question raises what scope remains for national healthcare policies and national public objectives concerned within the EU state aid regime. After looking at the application of EU state aid rules, the following set of questions within this chapter will be examined:

10 Communication from the Commission to the Parliament, the Council, the ESC and the Committee of the Regions on ‘Services of General Interest, including Social Services of General Interest: a New European Commitment’ accompanying the Communication on ‘a single market for the 21st Century Europe’, COM(2007)725 final (the ‘2007 Communication’)
11 Event: Hearings of commissioners designate: Vice-President designate Mr Joaquin Almunia, Brussels JAN4Q2, 12 January 2012.
What is the impact of EU state Aid rules on the healthcare sector?
What is the effect of EU state aid rules within the scope of the national healthcare policies?

Against this background, the answers of these questions will be outlined in the conclusion of this chapter and will subsequently be the foundation of the entire research within this thesis.

1.1 EU competition law

Under the EU state aid rules, the EU internal market is functioning as an efficient and self-regulated instrument, with no intervention by the government. This approach seems to be based on the desire to achieve further economic integration of Europe, with common provisions to ensure this process. During this political movement the objective of the internal market is further enlarged in order to advance consumer welfare.

The EU competition rules as well as the EU state aid provisions have direct effect, which means that national courts are bound to recognize and enforce them. Consequently, national courts of the different Member States have the responsibility to apply the common provisions on competition and state aid within their national legislation to protect competition in the market. This emphasizes the importance of cooperation between the Commission and the national government and thereby the exchange of information between competition authorities on both levels. Notably, the Commission has the exclusive power to provide clearance to declare aid compatible with the internal market. However, the central objective within this cooperation is established inter alia by the Court of first instance in the GlaxoSmithKline case of 2006; namely to prevent undertakings from restricting or distortion of competition in vertical and horizontal relations, which could be harmful for the well-functioning of the market and consequently reduce the welfare of the final consumer of the product. Moreover, only proportionate restrictions of competition are permissible and should be especially necessary to accomplish a general public aim. However, as we have seen above, aid granted by a public authority should be notified to the European Commission. Moreover, only the Commission could declare an aid to be compatible with the internal market. So far, we can see a highly centralized control by the Commission, which left no room for national courts. However, national polices are playing an more important role with regard to exceptions to the EU state aid rules

15 Council regulation (EC) No 1/2003, on the implementation of the rules of competition laid down in Articles 81 and 82 of the Treaty, 16 December 2002, nr. 9-16.
aid rules under the SGEI regime, which will be discussed in a further stage of this thesis. First we will look at the more general aspects of EU state aid law.

1.2 The application of EU state aid rules

Articles 107-109 TFEU concern the EU state aid regime, which is part of EU competition law. These rules are contrasting with the classic competition rules examined above, as the focus is not on undertakings exclusively, but rather on the interplay between a public authority and an undertaking. The focus of state aid law is more on procedure and good governance, instead of on effects in antitrust. The Article 107(1) TFEU comprises the substance of the state aid regime:

“[..] any aid granted by a Member State or through State resources in any form whatsoever which distorts competition by favoring certain undertakings or the production of certain goods shall, in so far as it affects trade between Member States, be incompatible with the internal market”.

Within this internal market, persons, goods, services and capital could be freely provided beyond the borders of every EU Member State. Article 1(a) of the Procedural Regulation (EC) No 659/1999 charges to explain 'aid' as any measure that fulfills all the criteria lay down in article 107(1) TFEU. Within the Commission’s task to control state aid, all conditions listed in article 107(1) TFEU should be satisfied. These conditions are: (a) transfer of state resources; (b) economic advantage constituted by the aid; (c) selectivity and (d) potential effect on competition and trade. The ECJ and the Commission have taken a broad view, since the content of state aid is not defined in the Treaty of the Functioning of the European Union. There will be aid, if the result of an intervention of the state leads to financial improvement or stabilization in the beneficiary’s position, which would not have occurred without any involvement of the state. Therefore it is not the form or purpose that is relevant for determining an aid but rather the actual advantage that the beneficiary gains. A comparison between the position of the recipient under normal circumstances with the position after the differential treatment of an undertaking by compensation from the state should be undertaken to consider whether a state measure could be an aid for the purpose of article 107(1) TFEU. The prohibition of state aid applies to services and/or economic activities practiced by undertakings. However, there are legal exemptions described in article 107(2) and 107(3) TFEU and aid can be provided by the state in special circumstances. In addition, the Commission has registered block exemptions in the General Block Exemption Regulation of 2008. Besides, state aid as public service

22 Commission Regulation (EC) No 800/2008 of 6 August 2008 declaring certain categories of aid compatible with the common market in application of articles 87 and 88 of the Treaty (General Block Exemption Regulation) (OJ 2008, L214/3)
compensation might be accepted through Article 106(2) TFEU on Services of General Economic Interest (SGEI), with regard to the costs incurred by undertakings in order to fulfill their social task. The SGEI concept plays a significant role with regard to public policy in healthcare and will be discussed in subsequent stages of this thesis.

The qualification of the entity involved is important with regard to the application of state aid provisions. Such qualification of the notion of 'undertaking' does not differ from the ECJ’s definition in the Höfner and Elser v Macrotron case in 1990. In Höfner, the Court described an undertaking as "every entity engaged in an economic activity, despite the legal status of the entity and the way in which it is financed and secondly, that employment procurement is an economic activity". Economic activity should be explained by offering goods and services on the market. Simply being a purchaser does not make an entity engaged in an economic activity. Therefore, the purchase should be related with a commercial activity.

As expressed by A.G. Jacobs in AOK in 2004, the character of the activity is more significant than the actors that doing the activity. Furthermore, he emphasized that not only the type of activity, but also the possibility of making profit from the supply of goods and services by a private undertaking is crucial in assessing whether economic activity exists. Therefore, each activity should be considered independently and requires a case-by-case examination.

Remarkably, with regard to the legal status of an entity it is not relevant whether the entity itself is profit or non-profit making. This is established in the case of Albany in 1996 where the Court made clear that non-profit making is not a sufficient element to release an undertaking from falling within the scope of competition law. Also in Höfner the ECJ determined that the competition rules are applicable, whatever the legal status of an entity is.

Article 106(1) TFEU applies to public undertakings, which therefore cannot be excluded from the scope of the competition rules of the Treaty. The Court amplified the irrelevance of the nature of an entity in Commission v Italy (1987) by pointing out that being a body of the state is not sufficient to eliminate the entity from falling into the scope of the competition rules.

Noteworthy is the contradiction of this judgment regarding article 345 TFEU which bans any Treaty involvement when it comes to the regulation of national property rights, as the determination whether an entity is public or private assets is supposed to be a national task.

1.3 Definition of 'undertaking' and healthcare; developments in case law

With regard to the evolution of ECJ case law, the strict division is between bodies managing social security schemes and healthcare providers is particularly evident. Decisive in the various

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23 V. Hatzopoulos, 'The concept of 'economic activity' in the EU Treaty: from ideological dead-ends to workable judicial concepts', Research papers in law, College of Europe, June 2011.
28 Communication on a single market for 21th century Europe Services of general economic interest, including social services of general interest; a new European commitment COM(2007) 725 final, p5.
31 F Case C-118/85 Commission v. Italy [1987] ECR 2599
cases is the perception of ‘economic activities’, to determine the precedence of undertakings and consequently the applicability of competition law. In Pavlov (2000), the ECJ determined that not only the purchase of goods and services could signify an undertaking, but also the financial risks that are attached to the economic activity have to be considered\textsuperscript{32}. Additionally, the activity should be offered in return for remuneration. In this context, the condition of risk-bearing made the medical specialists in this case portrayed as undertakings\textsuperscript{33}. To consider whether an entity should be regarded as an undertaking, the entity’s legal form or its method of financing are no longer the main variables. Recently, in the case AG2R Prévoyerance \textit{v} Beaudout Père et Fils SARL\textsuperscript{34} (2011) the Court found that the health insurer AG2R Prévoyerance had such a high level of autonomy, that it could be considered to be an undertaking. With regard to supplementary health insurance, the principle of solidarity and the level of state control are decisive\textsuperscript{35}. Given the broad definition of undertaking, the question raises whether entities within the healthcare sector (which is merely organized at national level) are covered by the highly centralized EU state aid control by the Commission.

1.4 The healthcare sector within the scope of EU state aid rules

Considering the broad interpretation of the notion of undertakings in combination with the upcoming competition concerning the costs of healthcare services and the length of waiting times, the healthcare sector is becoming more frequently subject of EU competition law and the EU state aid rules. In this sense, private based provision of healthcare services seems to increase.

Healthcare provision will be within the scope of the EU competition rules if the activity includes the supply of services or goods and there is potential competition regarding the circumstances\textsuperscript{36}. Therefore, at least most private healthcare providers are found to be undertakings\textsuperscript{37}. Being supported by measures of the state does not directly being exclude an activity from being of an economic nature. This occurred for instance in 2001 in the \textit{Ambulanz Glöckner}\textsuperscript{38} case, where (non-)emergency transport was not always supported by the state and these services were thus noticed as an economic activity. The provider of this activity (Glöckner) could be seen as undertaking under EU state aid law. It appears that the

\textsuperscript{32} Joined Cases C-180/98 to C-184/98 Pavel Pavlov and Others \textit{v} Stichting Penioenfonds Medische Specialisten [2000] ECR 1-6451 at para 75.
\textsuperscript{33} Joined Cases C-180/98 to C-184/98 Pavel Pavlov and Others \textit{v} Stichting Penioenfonds Medische Specialisten [2000] ECR 1-6451 at para 75.
\textsuperscript{34} Case C-437/09 AG2R Prévoyerance \textit{v} Beaudout Père et Fils SARL.
\textsuperscript{36} O. Oduu, ‘Are State-owned health-care providers undertakings subject to competition law?’, E.C.L.R. 2011, p. 235.
combination of public- and private healthcare providers and selective intervention by the government is significant to suggest that EU state aid law applies\textsuperscript{39}.

Nevertheless, with regard to providers of health insurance the ECJ has adopted another approach. Apparently, the services of (public) health care management bodies are concerned with the principle of solidarity. This approach proceeds from the developments within judgments of the ECJ. In 2002, the UK tribunal concluded in Bettercare II\textsuperscript{40} that the local authority could be found to constitute undertakings exclusively in its purchasing activities within the market. As the NHS Trust within the case was also providing healthcare services itself, the latter was in a position to restrict competition. This was for the British competition authorities enough to classify providers of health insurance concerned as undertaking. This contrasts with the \textit{FENIN} judgment where the Court of first instance took a different view on the concept of an economic activity\textsuperscript{41}. In \textit{FENIN}, the Court of first instance determined that the entity (purchaser of goods and services on the market) involved could be only considered as an undertaking within the purchase market, if this entity is effectively involved in the offering goods and services on the supply market\textsuperscript{42}. Not only in the \textit{FENIN} case, but also in \textit{AOK} (2004), the Court gave its opinion upon the application of the notion of undertaking to healthcare insurance and concluded that the German insurance funds were not undertakings for the purpose of article 101 TFEU. Since the health insurance had an objective social function grounded on the ‘solidarity’ principle, it could not be characterized as subject of EU competition law. This is also what the ECJ confirmed in the \textit{FENIN} case, by concluding that a purchasing activity is only an issue to competition law if it has an economic rationale rather than a social purpose. A non economic activity should have a providing function which is solely for the fulfillment of its social functions.\textsuperscript{43} In \textit{AOK}, Advocate General Jacobs focused on the factors of making profit, the presence of a social purpose and the degree of autonomy to verify the notion of undertaking. On account of the \textit{AOK} judgment, the Dutch government temporary changed its policy and the insurance funds so they were no longer regarded as undertakings. In the third chapter, we will see that the decision of the ECJ in \textit{AOK} contrasts with the Dutch state aid case on risk equalization, even though the facts of the cases were similar. Meanwhile, with the application of article 122 Health Insurance Act (Zvw), insurance companies (as well as hospitals) can be qualified as undertakings again\textsuperscript{44}.

\section*{1.5 Conclusion}

The main variable to determine whether the EU state aid rules are applicable to the healthcare sector or not, is the presence of an entity engaged in an economic activity in the meaning of

\textsuperscript{40} Case no CE/1836-02, BetterCare Group Ltd/North & West Belfast Health & Social Services Trust [2003],18 December 2003.
\textsuperscript{41} J. Skilbeck, 'FENIN: A Pyrrhic victory for public sector buyers?', Mockton Chambers, April 2003.
\textsuperscript{42} Case T-319/99 FENIN, 4 March 2003.
\textsuperscript{43} Case T-319/99 FENIN, 4 March 2003.
\textsuperscript{44} NMA 1998 zaak 165, Sophiaziekenhuis, NMa 2001 zaak 1437, Monuta vs Schieland Ziekenhuis/Matrice.
offering services and goods on the market. The scope of the notion of an ‘undertaking’, which is developed through ECJ case law, covers most forms of healthcare provision. In Pavlov (2000) as well as the Ambulanz Glöckner case (2001) 45, entities could fall within the scope of the concept of undertaking if they provide services for economic consideration. On the other hand, with regard to the provision of healthcare insurance the principle of solidarity seems to have a significant influence according to cases such as FENIN, Bettercare II and AOK46. Therefore, insurers are not caught by EU competition law when they act on the basis of this argument. Contrary, in 2005 the Commission declared the system of risk equalization in the Netherlands compatible with the EU state aid rules but from a different perspective, while the facts of the case were similar to AOK. As risk equalization was deemed to compensate risk problems, the Commission accepted the restrictions involved under the heading of a Service of General Economic Interest (SGEI). As we will see, this SGEI instrument (article 106(2) TFEU) could be designated at national level as exception to the state aid prohibition under article 107(1) TFEU. The main objective of this research is to examine what will be the impact of EU state aid law with regard to the SGEI exception on the Dutch healthcare system. Before discussing this impact, we should first outline some of the fundamentals of the SGEI instrument. Therefore, the next chapter focuses on the developments concerning the SGEI instrument within EU state aid law.

CHAPTER 2 SERVICES OF GENERAL ECONOMIC INTEREST

On the basis of article 107(1) TFEU Member States are not permitted to grant aid to undertakings if this would distort competition on the Internal Market. However, the legal exemption of article 106(2) TFEU states that restrictions on EU competition law and EU state aid law are afforded only if the anti-competitive behavior is very necessary for the execution of the tasks allotted to the public services. Notably, exceptions to the competition rules are kept to a minimum level by the application of the so-called ‘Services of General Economic Interest’ instrument. Based on the proportionality principle, granted aid should be appropriate, necessary and the deliberation on SGEI should include a balancing of the various interests concerned.

As the SGEI instrument should be designated at national level, the Member States have a broad margin for interpretation regarding the definition of the instrument, unless it complies with the rules on compensation which will be discussed further in the study. Evidently, this competence of the Member States has a rather significant value as the Protocol [9] on Services of General Interest (annexed to the TEU and TFEU by the Treaty of Lisbon 2006) accentuates that the Treaty can by no means restrict the powers of the Member States to provide and organize non-economic services of general interest.

Before starting on a more detailed examination on the application of the SGEI instrument within the healthcare sector, we should address some of the fundamentals. Therefore, within this chapter the research will be continued with an analysis of the SGEI instrument determined in article 106(2) TFEU, with regard to the recently tightened EU SGEI policy and developments within case law. After looking at the legal basis for SGEI within the FTEU, this chapter will examine the following set of questions:

- What is the role of the SGEI instrument in EU case law?
- How did the SGEI exception evolve within EU state aid law?
- What is the impact of the recently revised SGEI-package (December 2011) and what are the comments on this development?
- What would be the consequences of the new package for the Member States’ discretion to designate SGEI?

Against this background, the current role of the SGEI instrument in EU state aid law and national public policy will be outlined in the conclusion of this chapter.

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2.1 The legal basis for SGEI

Within the Treaty, Services of General Economic Interest have their legal basis in article 14 and 106(2) TFEU. Besides, a basis could also be found in article 36 of the Charter of Fundamental Rights (which has the same legal value as the EU Treaties according to article 6 TEU), which reads as follows:

“The Union recognizes and respects access to services of general economic interest as provided for in national laws and practices, in accordance with the Treaty establishing the European Community, in order to promote the social and territorial cohesion of the Union.” [emphasis added]

Among others, the universal access to healthcare for each EU citizen falls within the common principles of the Member States’ healthcare systems, grounded on this fundamental right.

Article 106(2) TFEU

Despite having article 36 as a starting point for the application of SGEI, the actual definition of this term is still not completely clear due to the Member States’ freedom of interpretation concerning SGEI. Member States are competent to classify public services that could be regarded as SGEI but must be grounded on the substance of article 106(2) TFEU which provides:

“Undertakings entrusted with the operation of services of general economic interest or having the character of a revenue producing monopoly shall be subject to the rules contained in this Treaty, in particular to the rules on competition, in so far as the application of such rules does not obstruct the performance, in law or in fact, of the particular tasks assigned to them. The development of trade must not be affected to such an extent as would be contrary to the interests of the Union.” [emphasis added]

Article 106(2) TFEU states that undertakings providing services within the meaning of SGEI will not be treated differently from other undertakings being active in the EU market. Therefore, article 106(2) TFEU could be seen as an derogation from the Treaty rules, as undertakings do have to comply with competition rules (article 101 and 102 TFEU) and state aid rules (article 107 and 108 FTEU), but only if these rules do not prevent the actual execution of the tasks by the state. This means that in case of an undertaking providing services which includes bearing economic risk, the competition rules are immediately applicable. Furthermore, undertakings carrying out ‘solidarity-based’ services, are not subject to these competition rules. The flexible reasoning provides the Member States a lot of leeway. Notably, social security providers could be classified as undertakings which have to act in accordance with the European competition rules (article 106(1) TFEU). However, anticompetitive behaviour as state intervention could be
Article 14 TFEU
Since the Treaty of Amsterdam (1999) added Article 16 EC, a new communautaire concept of public services became a substantive element in the determination of the scope of application of EU law.\(^{50}\) By the adding of this article, a new legitimacy was created to support the simplification of the fulfillment of competition rules simultaneously with public service objectives. The substance of Article 16 EC, and more specifically the allocation of SGEI competences to Member States, was defined by the General Court in the BUPA case (2008) which will be discussed in the third chapter.\(^{51}\) The Treaty of Lisbon (2009) replaced Article 16 EC by Article 14 TFEU, which reads:

> “Without prejudice to Article 4 of the Treaty on European Union or to Articles 93, 106 and 107 of this Treaty, and given the place occupied by services of general economic interest in the shared values of the Union as well as their role in promoting social and territorial cohesion, the Union and the Member States, each within their respective powers and within the scope of application of the Treaties, shall take care that such services operate on the basis of principles and conditions, particularly economic and financial conditions, which enable them to fulfill their missions. The European Parliament and the Council, acting by means of regulations in accordance with the ordinary legislative procedure, shall establish these principles and set these conditions without prejudice to the competence of Member States, in compliance with the Treaties, to provide, to commission and to fund such services.” [emphasis added]

Article 14 TFEU caused an expansion of the content of SGEI. Principally, the emphasis on ‘particularly economic and financial conditions’ (which should be taken into account while states are operating SGEIs) could be seen as an innovative point within the new provision. Although the three provisions listed above together with the notion of universal services are important for the approval of horizontal regulation on services of general economic interest in the TFEU, case law could be seen as a leading factor with regard to the current meaning of SGEI\(^{52}\) and will be discussed in the next paragraph.

### 2.2 The role of the SGEI-exception in EU case law

Unlike article 106(1) TFEU, which is addressed to Member States, article 106(2) TFEU is exclusively designed for undertakings who have been entrusted by the state with certain tasks. This means that an undertaking could be private or public but is at least assigned by the state


\(^{50}\) M. Ross, ‘Article 16 EC and Services of General Interest: From derogation to obligation’ (2000) 25 ELRev 22, 22.


\(^{52}\) D. Gallo, ‘EUI working papers, social security and health services in EU law: towards convergence or divergence in competition, state aids and free movement?’, RSCAS 2011/19, p. 2.
to fulfill certain functions. Frequently, it appears that the difference between issues concerning state aid and compensation could not be easily perceived because of the variety of types of reward for public services. This should be clarified first, before the role of the SGEI exception within regard to compensation for public services could be made explicit within this paragraph. To facilitate a comparison between both the compensation and state aid approach, judgments from recent case law are set out in order to offer some guidance in the determination of compatible aid.

As already mentioned, article 106(2) TFEU does not offer a strict description of the character of the instructed tasks. Therefore the question whether, or in what circumstances compensation for SGEI could be seen as compatible state aid under article 107(1) TFEU still remains. As we have seen in the first chapter, four criteria for the finding of an aid are listed in article 107(1) TFEU. These are: (a) transfer of state resources; (b) economic advantage constituted by the aid; (c) selectivity and (d) potential effect on competition and trade. Besides the lacking legal description of SGEI, the value of the SGEI it is not evident, even as the way it should be promoted or protected by Member States. In previous cases such as BRT v. SABAM (1974), the Court decided to interpret the text of article 106(2) TFEU very narrowly, in order to give the competition rules a prominent position. In the case of Corbeau (1993) the Court is willing to be more flexible in the way it applies the criterion in article 106(2) TFEU, to the prejudice of the strictness of competition law. Member State could grant special or exclusive rights, but only if the conditions of article 106(2) TFEU are fulfilled. In the judgment in Corbeau, the Court states that competition rules can be left out of consideration to the extent necessary to protect the operation of a SGEI through cross-subsidy. However, the undertaking concerned should complete the criterion of having ‘economically acceptable conditions’ and also perform its tasks sufficiently balanced in order to compensate the less profitable sector. Essential with respect to the compensation approach is the absence of a selective advantage in order to conclude that no aid in the context of article 107(1) TFEU is involved. On the other hand, according to the state aid approach an existing aid could be considered as compatible. However, the compensation approach has appeared to be more in line with the Commission’s policy. Eventually, within the Altmark judgment of 2003 the latter has been embraced by the Court of Justice who elucidated the approach by means of a four-part analysis for its application.

The original Altmark Judgment
Over the course of numerous years, the ruling on state aid and the compensation for SGEI became more specific since the European Court of Justice put an end to the long-standing dispute in the Altmark case in 2003. Conclusions from a range of earlier cases culminated

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54 Case C-320/91, Paul Corbeau [1993] ECR 1-2563
57 Case C-280/00, Altmark [2003] ECR I-7747
in the special approach developed by the ECJ towards state aid and the concept of SGEI. Previously, in the case of Ferring (2001), the implication by the ECJ on possible conclusions with regard to the classification of state aid was very limited. In the Altmark case, the ECJ adopted another course: although there may be a confirmed state aid, this compensation could be still compatible with the EU competition rules if grounded on the SGEI exception of article 106(2) TFEU.

As already mentioned in the first chapter, for existence of state aid there must be an intervention by the state (or state resources) which is liable to affect trade between Member States. This intervention could be for instance the provision of subsidies or the remission of charges of a company concerned. In this manner, the state provides an advantage on the recipient which (threatens to) distort competition in the common market. The ECJ decided in the Altmark-case (2003) that the financial compensation of Public Service Obligations should not be notified to the Commission respecting four strict criteria. This provided that compensation should be limited to the costs that an efficient supply of service has made with the accomplishment of that duty. Four ‘Altmark-criteria’ should be fulfilled to confirm that these services of general economic interest (SGEI) do not fall within the definition of state aid. To determine the applicability of state aid rules, it should be determined

"whether a public support put the recipient undertaking in a more favorable comparative position than the other undertakings competing with them."

In order to identify compatible Public Service Obligations (PSO), four cumulative Altmark-conditions should be met:

1. The recipient undertaking is actually required to discharge public service obligations and those obligations have been clearly defined;
2. The parameters on the basis of which the compensation is calculated have been established beforehand in an objective and transparent manner;
3. The compensation does not exceed what is necessary to cover all or part of the costs incurred in discharging the public service obligations, taking into account the relevant receipts and a reasonable profit for discharging those obligations;
4. Where the undertaking which is to discharge public service obligations is not chosen in a public procurement procedure, the level of compensation needed has been determined on the basis of an analysis of the costs which a typical undertaking, well

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60 Case C-53/00, Ferring [2001] ECR I-9067.
64 Case C-280/00, Altmark [2003] ECR I-7747, p. 87.
run and adequately provided with means of transport so as to be able to meet the necessary public service requirements, would have incurred in discharging those obligations, taking into account the relevant receipts and a reasonable profit for discharging the obligations.\(^\text{65}\)

Therefore, compensation which complies with these criteria is not considered to be state aid and thus not prohibited under article 107(1) TFEU. Moreover, if the national measure meets the described conditions, there is no need for notification of the compensation to the Commission on the basis of article 108(3) TFEU, which is generally required for aid.

However, where the conditions for the application of article 107(1) TFEU are not fulfilled and in case the Altmark exception does not apply, there is still an escape path: the aid could be considered as an SGEI exception under article 106(2) TFEU. On the condition of notification of national state measures to the Commission, the exemption under article 106(2) TFEU could apply. The SGEI exception appears to be rather beneficial with regard to market failures within a competitive market, as we will see within the (Dutch) healthcare system in a further stage of this research. However, it should be noted that the SGEI alternative is not an absolute one: compensation should be on the lowest possible level (what is necessary to comply with public interest objectives) and the recipient undertaking must not receive any competitive advantage.\(^\text{66}\) Generally, exceptions on the state aid rules should be limited by the application of SGEI, by means of a proportionality test.\(^\text{67}\) Several developments to the SGEI exception has been taking place since the state aid ruling of the Altmark-case of 2003. Before covering the most recent developments with regard to the SGEI instrument, we will take a few steps back in order to recap some of the fundamentals of the SGEI evolution.

## 2.3 Evolution of the SGEI instrument within EU State Aid Law

First developments with regard to the SGEI instrument took off since the 1996 Communication by the Commission on Services of General Interest in Europe.\(^\text{68}\) This document clarified the topic and emphasized the importance of the promotion by the Community of services of general interest. A legal basis of SGEI was created by the introduction of article 16 EC which has been replaced by article 14 TFEU. The former is an obligation on Member States to take care that these public services operate on the basis of in particular economic and financial conditions. In this way, article 14 TFEU accentuates the importance of a well-functioning competitive social market as a common EU value.\(^\text{69}\) This provision was further detailed in Protocol No. 26 on Services of General Interest to the Treaty. With the Commission’s 2003

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\(^{65}\) Case C-280/00, Altmark [2003] ECR 1-7747, p. 95.


\(^{68}\) Communication from the commission, services of general interest in Europe, COM (96) 443 Final, Brussels 11 September 1996.

\(^{69}\) Protocol (no.26) on Services of General Interest, *Official Journal* 115, 09/05/2008 P. 0308 – 0308.
white and 2004 green papers, common public service targets and, moreover, the distribution of SGEI competences between Member States and the European Union became clearer.

Nevertheless, the role of the SGEI exception is still under discussion. Evidently, there has been substantial progress of legal certainty since the adoption of the 2005 SGEI Package (‘Monti-Kroes’ rules of 2005). According to the Monti-Kroes package (2005), state aid could be presumed to be compatible with the EU treaty in terms of compensation granted to undertakings for the provision of public service obligations. Based on the Altmark judgment of 2003, this package includes general criteria to determine when compensation as such would not be ’state aid’. However, problems still remain, such as wrong application of the rules, heavy administrative burdens for small SGEI, an insufficient method to check overcompensation and inefficient provision of SGEI. Therefore, these problems were subject of the reform of the original SGEI package by the European Commission on 20 December 2011 (‘Almunia reform’).

The new package concerning EU state aid rules on the assessment of compensation for Services of General Economic Interest came eventually into force on 31 January 2012 and elicits certain alterations in the present EU policy. Additionally, the Commission adopted the de minimis Regulation within the scope of SGEI on 25 April 2012.

With the adoption of this new EU package on the assessment of public compensation for SGEI, the European Commission strived for a simpler and more flexible approach regarding the assessment of SGEI. This is illustrated by three key objectives: clarification, simplification and diversification. What still persists is the Member State’s competence to define a SGEI, albeit the financial support of the provision of these services should not cause any restrictions of competition within the Internal Market.

In order to clarify this competence, the new SGEI package comprises four instruments which are applicable by all authorities. Hence national, regional and local powers are able to finance the provision of SGEI unless grounded on the following documents:

- A communication; includes the general concepts of state aid law which are important for the classification of SGEI. (i.e. clearing up the Altmark conditions, aid, economic activity)

70 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 [2005], L31 2/67.
72 SEC (2011) 1582 Final, Reform of the EU rules applicable to State aid in the form of public service compensation, Commission Staff working paper, Brussels 20 December 2011.
73 Commission Regulation no. 360/2012, 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 Text with EEA relevance, 25 April 2012.
- A *Decision*; expansion to a more extensive list of SGEI-categories which do not need to be notified to the Commission. Moreover the notification threshold is reduced to an amount of 15 million euro.

- A *Framework*; Large compensation amounts on behalf of funding undertakings outside the social services (utility services such as energy services, transport and electronic communication) field could be, unless notified to the Commission, tolerated under certain criteria. This instrument goes further into specifications within the method on the establishment of the extent of this compensation.

- A Proposal (!) for a *De Minimis Regulation*; which includes a threshold that could discharge irrelevant amounts of compensation from state aid scrutiny. (This *de Minimis Regulation* was eventually adopted on 25 April 2012)

Reflecting on the above defined instruments within the new SGEI package, various innovative approaches can be observed. While formerly only hospitals and social housing were released from the obligation of notification to the Commission, now the scope of public services which can escape from notification is expanded according to the *Decision*\(^ {75}\). The condition reads as follows:

> “social need as regards health and long term care access to and reintegration in the labor market, social housing and the care and local inclusion of vulnerable groups”\(^ {76}\).

Currently, other social services such as childcare and the access and/or reintegration in the labor market are also integrated within the revised decision\(^ {77}\). Therefore, for all these services, the standard of the ‘stand still obligation’ is lifted, which means that hospital and social housing services could be exempted from the previous notification requirement of article 108(3) TFEU. Consequently, social services, hospital and emergency services benefits from a more generous exemption policy. Apart from these specific exemptions, the general threshold is lowered, catching more aid. Whereas under the old package notification to the Commission should be accomplished when the amount of compensation was higher than 30 million euro, under the revised *Decision*, this threshold is lowered to 15 million euro. Consequently, certain aid that does not cover this amount, will avoid suspicion of incompatible state aid.

The third instrument, the new *Framework*\(^ {78}\), offers a methodology to determine and strictly control the quantity of large compensation which falls outside the scope of social services. It also requires Member States to arrange their compensation mechanisms efficiently while keeping in mind the rules on public procurement and equal treatment. Existing compensation

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that potentially restricts competition within the Internal Market should be at least diminished by the Member States.  

The proposal for de Minimis Regulation\(^{80}\) as a final instrument, has been recently adopted by the European Commission on 25 April 2012. This regulation exempts compensation of an undertaking by the state from notification to the Commission, if this support does not go beyond the threshold of 500,000 euro over a period of three years\(^{81}\). It is remarkable that the de minimis threshold within the state aid rules is only an amount of 200,000 euro over three years. Evidently, state aid measures associated with SGEI objectives are supposed to cover at least the extra costs that in particular small companies will have because of the accomplishment of public services obligations.\(^{82}\) The reasoning behind the de minimis Regulation is clearly illustrated by Joaquin Almunia:

"European citizens need both strong public services and an efficient internal market based on strong competition rules. This new exemption will facilitate the provision of many small, local public services and will also help the Commission focus its efforts on cases where state aid has a real impact on competition and trade between Member States\(^{63}\). (Competition Commissioner Joaquin Almunia )

Although the revised package includes an obviously welcome illustration of various aspects of the SGEI policy, a strict method with regard to the interpretation of the notion of SGEI is still missing. An important question at this stage: What are the consequences of this new package for the national policies on SGEI?

**2.4 EU Member States’ discretion to define SGEI**

Within the revised SGEI package he Commission has introduced the innovative term ‘genuine SGEI’. State aid could be only compatible by means of the accomplishment of a genuine and correct SGEI, according to paragraph 12 of the Framework\(^{84}\). A precise explanation of ‘genuine SGEI’ is missing, but the Member States should indicate that the public services concerned are supported in an appropriate way.

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How the competences to definite SGEI should be distributed could in particularly be found in the new Commission Communication. Based on Protocol no. 26, the Member States should at least organize SGEI closely to the needs of the users, by means of the delegation of provision and commissioning SGEI to authorities on different levels (Article 1 Protocol no. 26)\(^\text{85}\). Furthermore, the Member States still have the competence to assess a certain service to be a SGEI, in terms of lacking specific EU rules on the matter. Hence the Member States have a considerable margin of discretion to decide on which services could be assigned as SGEI. However, as discussed earlier, the critical point is whether the broad margin of appraisal would be actually beneficial for the actual social services concerned such as, for instance with regard to the Dutch healthcare sector where the Dutch Healthcare authority (NZa) is ultimately following the directions of the Ministry of Health, Welfare and Sport which colors the interpretation of SGEI by rather political deliberations.

Although the new Communication includes that the Commission could intervene in terms of incorrectly defined SGEI, this competence is confined by the supplement of paragraph 41:

> “The Commission’s competence in the respect is limited to checking whether the Member State has made a manifest error when defining the service as a SGEI”\(^\text{86}\).

Due to the new rules within the new Commission Communication, the Commission has certain power to control the national policy on the provision of SGEI. Mainly with regard to services that do not fall within the scope of social interest, the Commission will strictly control the amount of compensation which exceeds the threshold of 15 million euro. Furthermore, the new text includes the prohibition of compensation to services that are already (or could potentially) be provided adequately under normal market conditions. Although the Member States have a wide margin of discretion in designating SGEI\(^\text{87}\), the Commission should control on manifest error in the application of the SGEI exception. Moreover, paragraph 43 of the Communication prescribes:

> “the services to be classified as SGEI must be addressed to citizens or be in the interest of society as a whole”\(^\text{88}\).

Notably, this appears to be inconsistent with the BUPA case (which will be discussed in the third chapter) where the General Court based its qualification of a universal service no longer on the condition of meeting a demand of the entire population, but on a limited group of users (depending on the characterization of undertaking)\(^\text{89}\).

\(^{85}\) Protocol (no.26) on Services of General Interest, *Official Journal 115*, 09/05/2008 P. 0308 - 0308

\(^{86}\) 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, *Official Journal C8*, 11.01.2012, part 3.2.

\(^{87}\) S. Rodrigues, ‘Main areas of Concern from an Economic and legal Perspective Elements of discussion’ (College of Europe Seminar), Brugge, 30 September 2011.

\(^{88}\) 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, *Official Journal C8*, 11.01.2012, p. 43.

Comments on the new SGEI package

The new SGEI package sets out a guideline to determine which compensation measures by the state will not be assumed as incompatible under article 107(1) TFEU. Although the four instruments are valuable to estimate the conformity of SGEI compensation with the EU state aid rules, not all aspects of the new package are coherent. Principally, no specific approach is included with regard to the actual qualification of services that include a public interest obligation. Obviously this does not benefit legal certainty, as national courts maintain the same freedom of interpretation within the application of EU state aid rules to SGEI. For instance, there are certain sectors, such as social housing and hospital services, which are excluded from the duty of notification of compensation to the Commission. Although it appears that this commitment provides Member States more flexibility to support those sectors, no clear guidance is available on the specific definition of SGEI objections.

Without doubt, the Framework is assumed to be the most debatable document within the package. First, the procedural conditions of paragraph 12-20 of the Framework are subject to criticism. These conditions are significant to determine if SGEI compensation is compatible with the Internal Market. Generally these conditions appear to be not strictly of economic nature, but incorrectly based on the social needs and cultural and political history of an individual Member State. However, this freedom of interpretation is limited by paragraph 10 of the Framework, which excludes services that could be considered as satisfactory provided from SGEI obligations. This phrasing is remarkable as it contrasts with the TV2 case where the General Court concluded that the competence to assess public services by the Member State should not be deprived since the definition of public services is considered as an exclusive national task. By the introduction of the new Framework, large aid cases will be more under the Commission’s scrutiny as Member States have to provide public consultation or other suitable methods before entrusting a Public Service Obligation to a provider. It is also remarkable that there is an emphasis on effectiveness, as it is questionable whether this focus is entirely covered by the Altmark case. Nevertheless, the Commission’s power to decline the scope of interpretation allocated to the Member States is limited.

Furthermore, the new methodology to estimate the valuate the SGEI compensation is subject to criticism. Due to the Framework, the support by the state should not exceed a certain amount of payment (included the reasonable profit) which is assumed to be required to provide the SGEI (so-called 'net cost calculation'). Hence, this technique is used to consider the presence of overcompensation for SGEI. Nonetheless, this process is understandable.

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regarding the current financial crisis, which forces the State to provide public service compensation in an efficient and sensible way. Finally, the Framework includes the possibility of the Commission to set additional requirements in cases of more serious distortion of competition within the Internal Market. As result, the Commission can freely decide on compatible SGEI compensation based on a (already reduced) category of serious distortions and types of commitments. We have seen that the new SGEI package aims to give more certainty for Member States regarding the classification of public services obligations and therefore the application of state aid rules on SGEI. However, it remains questionable if a strict regulation of the concept of SGEI is really desired regarding the political sensitiveness of the topic within the EU policy.

2.5 Conclusion

The concept of SGEI has its legal basis in article 14, 106(2) TFEU and article 36 of the Charter of Fundamental rights. Particularly important for the application of the SGEI exception are the four criteria of the Altmark judgment (2003), which were eventually adopted within the SGEI-package (Monti-Kroes) in 2005. The revised 2011 SGEI package includes criteria to consider the conformity of state aid as SGEI compensation with the Treaty. The focus of this package is on efficient application, the compliance with public procurement procedures and on determination of a reasonable amount of SGEI compensation. Obviously, the package should offer clarification, simplification and diversification regarding the assessment of SGEI, which is a welcome improvement particularly with regard to decentralized authorities who run frequently into difficulties. Within the revised SGEI package, the Communication and the Decision includes a clear explanation of the concepts of ‘economic activity’ and ‘reasonable advantages’.

In spite of the tightened guidelines on the implementation, the assessment of SGEI is confirmed as a national task in practice. Therefore, the SGEI instrument could be seen as the most flexible exception on EU state aid law. Obvious within this competence, the conditions of proportionality and subsidiary should be respected. Furthermore, the Commission has a certain power to control the national policy on SGEI, in particular to detect overcompensation by the use of the ‘net avoided cost’ methodology. Intervention by the Commission will be in particular with regard to large aid cases; social services, hospital and emergency services will benefit from a more generous exemption policy. In contrast, with regard to compensation of public services which fall outside the Decision (utility services), the control on these services has been tightened and the aid threshold is lowered. However, a more proportionate approach towards small SGEI which have just a little effect on competition will be beneficial for the


97 Case C-280/00, Altmark [2003] ECR 1-7747.

decentralized authorities charged with public service obligations. In particularly with regard to the healthcare sector, could the further clarified SGEI exemption be a sufficient instrument in order to provide public services without the risk of being regarded as state aid in the sense of article 107(1) TFEU? In order to answer this question, we now look more closely at the effect of the SGEI exception within the healthcare sector.
CHAPTER 3 THE SGEI EXCEPTION WITHIN THE HEALTHCARE SECTOR

So far, we have discussed the role of the SGEI exception with regard to the compensation of public services. We will now turn to the SGEI instrument within the healthcare and health insurance sector.

To accomplish a multi-level governance system within the EU, several competences are reserved to the national authorities of the Member States. Based on the subsidiarity principle under article 5 TEU, the EU should only intervene, if objective cannot efficiently be accomplished at national or regional level.

The organization and delivery of healthcare is an area where Member States have a certain responsibilities based on article 168(7) TFEU (ex-article 152(5) EC). Moreover, the principle of a universal coverage of the healthcare objective is endorsed by article 35 of the Charter of the Fundamental Rights which states that,

“Everyone has the right of access to preventive healthcare and the right to benefit from medical treatment under the conditions established by national law and practices”99.

Due to the strong connection between social services and social protection within the Member States, a part of the healthcare services could be easily linked with the (national) general interest objective. However, healthcare services are not always linked with merely social issues. As already mentioned in the first chapter, not only healthcare provision but also healthcare insurance can have a rather economic character. Various providers within the healthcare sector, classified as undertakings, create competition and are therefore forced to comply with EU competition rules under article 106(1) TFEU. Therefore, the SGEI exception under article 106(2) TFEU may be a useful legal instrument to protect the public interest by state intervention within the competitive healthcare market.

Having looked at the basics of the EU state aid rules and the SGEI concept, we will now examine the impact of the SGEI exception within the healthcare sector. As we have seen the organization of healthcare is highly decentralized, which is conflicting with the centralized system of state aid control. This raises the question whether the SGEI exception could play a sufficient role within the healthcare policy. In order to answer this question, in this chapter we will address the following set of issues:

- What are the differences between the Altmark criteria and the 2011 SGEI package?
- What was the impact of the IRIS-H Decision and the risk equalization cases on the role of SGEI exception within the healthcare sector?

- How will the 2011 SGEI package relate to the healthcare sector?

In the light of all this, the current application of the SGEI instrument within the healthcare sector will be outlined in the conclusion of this chapter.

3.1 State aid and the SGEI exception: developments in the healthcare sector

Although Member State’ policies frequently differ from each other, there is a shared desire to pursue policies in the public interest at national level. However, different values and priorities of the various states thwart the actual definition of the so-called public services. Despite the prohibition of state aid within article 107 TFEU, article 106(2) TFEU provides a SGEI exception that is set up to guarantee a high quality of these public services. Art 106(2) TFEU could be seen as a ground for exceptions in relation to EU competition rules, but only if the service covers a particular public service obligation which is entrusted to a specific undertaking. What causes the obscurity is the determination of a SGEI, which is the responsibility of the Member States themselves.

Moreover, the divide between private and public services has become increasingly vague since the process of liberalization. This made provision of public interest services by the state combined with competition law principles a much discussed topic. Both utility services (e.g. energy and telecommunication) and social services such as healthcare are included in the debate on how SGEI could be delivered. The difference between the two types of services may be the lack of EU harmonization framework at the healthcare-front. This emphasizes the flexibility to assign healthcare services that may constitute SGEIs at the level of the individual Member States. As already mentioned, the focus of this chapter will be on the impact of the SGEI exception within healthcare. In order to examine this impact, the next section covers some useful illustrations.

3.2 The IRIS-H Decision

It has been observed that the four Altmark criteria play an important role within the determination a form of compensation (instead of an aid) for public service provision. If the four criteria set out by the Court are met, the compensation concerned does not need to be notified to the Commission. However, if there is aid based on the Altmark criteria, services may be still compatible with the internal market under article 106(2) TFEU. As we have seen in the previous chapter, the compensation will not be examined under the EU state aid rules if four cumulative conditions are met. First of all, (1) the recipient undertaking is actually required to discharge public service obligations and those obligations have been clearly defined. Moreover, (2) the parameters on the basis of which the compensation is calculated have been established beforehand in an objective and transparent manner. Notably, (3) the

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100 IP/11/1579, Commission adopts quality framework for services of general interest in the EU, 20/12/2011.
compensation does not exceed what is necessary to cover all or part of the costs incurred in discharging the public service obligations. Finally, (4) where the undertaking which is to discharge public service obligations is not chosen in a public procurement procedure, the level of compensation needed has been determined on the basis of an analysis of the costs of a typical well-run undertaking. Notably, the focus within the fourth condition is on comparable efficiency of similar undertakings. The fourth condition has a shifting role within the development of the SGEI-exception, which will be discussed below.

A useful illustration of the impact of the SGEI exception on healthcare services, is the IRIS-H Decision (2009), which remains the first full EU state aid decision of the Commission with regard to the hospitals sector. The Commission decided to examine the compatibility of the financing of public hospitals in Brussels by the government of Brussels. These so-called IRIS hospitals (IRIS-H) were supported by public resources, in order to balance their budgets ("deficit funding"). Notably, the IRIS-hospitals have an additional public services obligation (alongside the 'standard' PSO). The IRIS-H were obliged to treat every patient, which meant that a set of hospital services could be maintained at every location. According to the plaintiffs, not only public but as well private hospitals were subject to this PSO. This means that the public service compensation may not be compatible with the internal market.

The Commission argued that the four Altmark criteria should be applied ex tunc (situation from the outset), as confirmed in the BUPA (2008) case, which will be discussed in the next section. However, the Commission only took into account the first and fourth criterion to determine whether the financing of the IRIS-H could be regarded as aid or a form of compensation. The first criterion was that the undertakings are entrusted with a SGEI and the fourth criterion was that compensation must have been based on public procurement procedures or on the cost of a similar effective undertaking. According to the Commission, the fourth criterion could not be met and therefore the financing could be regarded as state aid as mentioned in article 107(1) FTEU. However based on article 106(2) TFEU under the 2005 SGEI package, the Commission stated that this aid could be considered as compensation for the hospital’s services of general economic interest and therefore compatible with the internal market. Furthermore, the requirements of necessity and proportionality were met. Based on separate internal accounts for SGEI - and non-SGEI services provided by the IRIS-H, no overcompensation or cross subsidies of economic (and competitive) activities could be proven. The IRIS-H Decision demonstrates, again, the flexibility at the national level with regard to the interpretation of the SGEI exception. However, in the meanwhile this flexibility has been

104 W. Sauter & L. Hancher, ‘This won’t hurt a bit: the Commission’s approach to services of general economic interest and state aid to hospitals’, DP 2012-012, 21 March 2012.
limited. Recently, on 7 November 2012, in case T-137/10\textsuperscript{107} the Court invalidated the Commission’s Decision of 2009, grounded on a stricter policy. Therefore, the absence of overcompensation of the SGEI activities by the IRIS-hospitals could not be guaranteed. Consequently, the compatibility of the aid granted by the Belgian state within the internal market was not grounded on a formal consideration process and the Commission’s Decision of 2009 has been nullified by the Court.

Notably, there is an important difference between the Altmark criteria and the 2005 SGEI Package: the fourth Altmark criterion on efficiency is missing under the SGEI Package. Therefore, the latter includes a balancing of interests and allows full compensation of costs without any consideration of comparable efficiency. Moreover, the Altmark criteria apply ex tunc, while the SGEI package exclusively applies from the Decision of December 2005 (resp. from the Framework of November 2005)\textsuperscript{108}. Recently, the 2005 SGEI package has been replaced by the 2011 SGEI package which came into force on 31 January 2012. This revised SGEI package will be examined in the last paragraph of this chapter. First, we will look at the impact of the SGEI exception on the healthcare insurance.

### 3.3 The risk equalization cases

State aid law leaves its mark on the health insurance sector, in particular in the schemes of risk equalization. Healthcare insurers are covered by a risk-equalization system, which could compensate high medical expenses. Therefore, this will protect consumers from market failures such as adverse selection and the problem of moral hazard. The system includes both ex ante and ex post payments, whereas the latest is assumed to be the most unwanted as it does not fully cover the ‘risk element’\textsuperscript{109}. Remarkably, for a certain period no public compensation matters are related to these schemes and therefore no legal act is available to entrust a company with a SGEI. However health insurance companies assigned with a SGEI could be tolerated within the broader legal context\textsuperscript{110}. Risk equalization measures are taken by the state are in order to comply with the public aim – affordable health insurance. In order to comply with this public aim, certain small restrictions on competition will benefit the actual competition on the market concerned (competition on the merits instead of adverse selection). An illustration of the desirable mixture of solidarity and competition within the health insurance sector is the Dutch Health Insurance Act (1986-2005)\textsuperscript{111}. The activities of the Dutch insurance companies are based on this act, which enables them to operate for-profit. Consequently, this

\textsuperscript{107} Case T-137-10, Coordination bruxelloise d’institutions sociales et de santé (CBI) tegen Europese Commissie, 7 november 2012.


\textsuperscript{110} These were decisions concerning risk equalisation schemes in Ireland and the Netherlands: Aid measure N46/2003, Risk equalization system—Ireland; Aid measures N541/2004 and N542/2004, Financial reserves and risk equalisation system—The Netherlands.

makes the insurers undertakings and thus subject of EU state aid law. Whereas Dutch private health insurers were permitted to benefit from a risk equalization scheme (which is under the control of a state authority), a possible application of article 107 TFEU was argued by the Commission. In this consideration the Commission concluded that the Dutch risk equalization scheme was not meant to compensate costs, but rather to compensate risk problems. Therefore, the fourth condition of the Altmark ruling was not fulfilled.\(^{112}\) Therefore, the system was declared compatible with the state aid rules, as an exemption from competition under the heading of SGEI.

As already mentioned in the first chapter, in de AOK\(^{113}\) case (2004) the ECJ confirms the possibility of profit-making as a condition for the classification of an undertaking. Therefore, the Court gave its opinion upon the application of the notion of undertaking to healthcare insurance and concluded that the German insurance funds were no undertakings, because of their objective social function. This stands in contrast to the decision of the Commission in 2005 with regard to the Dutch risk equalization system\(^{114}\). This conclusion is remarkably as the facts of the Dutch case were similar to AOK\(^{115}\).

Moreover, in the Dutch scheme ex ante paid compensation was a point of discussion, as this could restrict the opportunity to compete more than compensation in advance (compensation ex post; as we will discover in the BUPA case (2008), where the General Court rejected the application of article 107 TFEU). It is noteworthy that the Health Insurance Act case was not assigned to the Court of First Instance and for a certain period no more examples of the establishment of a SGEI within the Netherlands could be observed.\(^{116}\) Nevertheless, in the fourth chapter we will discuss an important development at the SGEI-front with regard to the Dutch healthcare policy.

With regard to risk equalization, an innovative development took place on account of the judgment of the General Court in the much-discussed British United Provident Association\(^{117}\) (BUPA) case of 2008, as it further outlined the margin of discretionary power exercised by Member States with regard to social issues. The Member States gained more control of the regulation and financing of SGEI. In the BUPA case health care objectives were under discussion, which makes the final judgment of the General Court significantly valuable. The


BUPA case is useful as it illustrates how the use of the state aid rules and the Altmark conditions should be implemented in the healthcare sector. BUPA concerned the voluntary private supplementary health insurance in Ireland, which operates alongside the public health insurance system. Subject of the case was an Irish risk equalization scheme which was approved by the Commission. Noteworthy the Irish scheme is based on ex post compensation instead of the ex-ante compensation within the Dutch scheme. Obviously in BUPA the Court has a more lenient approach of the four Altmark conditions. Member States have a broad margin of appraisal concerning the definition of SGEI, but also with regard to the determination of cost compensation. Consequently the organization of the healthcare sector remains mainly a task of the national government. Besides the Court in the BUPA case has merged the concepts of SGEI and universal service referring to the Altmark criteria. The third and fourth condition does not apply strictly within certain – at least with regard to the healthcare insurance sector – circumstances. However, the compensation should be at least in accordance the purpose of these two conditions. According to this approach less compensation measures should be considered as state aid and therefore should not be notified to the Commission. At the time this Commission’s decision was based on the obsolete and rather vague Ferring ruling (2001). The Commission concluded that an ex-post compensation is necessary in order to guarantee the continuity of the system. From this perspective, over-compensation never occurs. It is even more likely that the risk equalization system concerned could result in under-compensation. Consequently, the Commission decided that the Irish scheme could be seen as compensation for the benefit of a public service obligation. Therefore the Irish Risk equalization scheme did not constitute state aid and could be considered in the light of the entrustment of a special task falling under the SGEI exception of article 106(2). The Commission concluded that the Irish risk equalization scheme was compatible with EU state aid law.

Moreover, within the Azivo case (2006) the issue of income redistribution came up for discussion, instead of the relatively subordinate health risks which were subject of the BUPA judgment. As the Commission now based its decision on a more complete view of the financing scheme of the Dutch healthcare system, which includes both ex ante - as well as post compensation. Unfortunately, the Azivo case was withdrawn from the register of the Court so there has not been a final judgment on the accurateness of the Commission’s approach regarding the Altmark requirements.

121 Case C-53/00, Ferring [2001] ECR I-9067.
As we have seen above, the scope of SGEI under article 106(2) TFEU is substantially broadened, as the Court based qualification of a universal service no longer on the condition of meeting a demand of the entire population. Consequently, the Court has supported financial aid to public services that only benefit a limited group of users, depending on the characterization of the undertaking concerned. To determine which kind of universal services will be taken into consideration, the national legislation on SGEI is instructive. However, the SGEI have to comply with certain common obligations, such as having a non-discriminatory character and providing all customers a minimum level of quality. Moreover, the proportionality test should be kept in mind while classifying SGEI. In the BUPA case the aim of the Irish scheme was to ensure access to health care for every citizen, based on open enrollment for every insurer. In this sense the public interest should be balanced with common market objectives, which leads to the application of the SGEI exception under article 106(2) TFEU.

In accordance with the described developments in previous case law, different types of market failures within health care markets could be covered by an SGEI justification of intervention by the state. Noteworthy is the test of the economically acceptable circumstances established in Corbeau, which should exclusively protect the undertaking entrusted with a SGEI from so-called ‘cherry picking’ (the search for the most beneficial activities by commercial undertakings in the sector). This problem, and also market failures such as adverse selection and information asymmetry, could be efficiently prevented since SGEI duties are addressed to healthcare insurers, in particular by means of risk equalization. The Commission appears to recognize the necessity of compensation for public service costs within the healthcare sector. Therefore, we will now look at how this need is provided for in the 2011 SGEI package.

### 3.4 The impact of the revised SGEI package on the healthcare sector

As we discussed in the previous chapter, the Commission introduced a revised SGEI-package to deal with state aid and the SGEI exception in December 2011. This new package...
consists of four instruments which are applicable to public authorities that grant recompense for the provision of SGEI. These four instruments are: a new Communication\textsuperscript{132}, a new de minimis Regulation\textsuperscript{133}, a revised Decision\textsuperscript{134} and a revised Framework\textsuperscript{135}. Particularly, the scope of SGEI within the healthcare sector has been broadened substantially by the introduction of the Altmark Package Mark II under the new 2011 Decision\textsuperscript{136} and 2011 framework\textsuperscript{137}. Below we will address the most relevant modifications with regard to the healthcare sector.

First of all, in the new Communication\textsuperscript{138}, the Commission clarifies the basic principles of EU state aid law which are relevant for SGEI. Regarding healthcare, in the Commission goes further into the definition of undertaking with regard to healthcare providers. Based on the principle of solidarity, universal coverage and/or a non-economic healthcare activity (as determined in Pavlov(2000))\textsuperscript{139}, could be concluded that healthcare providers are not acting as an undertaking\textsuperscript{140}.

Moreover, the 2011 Decision contains an extended definition of healthcare services under article 2(1)b and 2(1)c. Consequently, hospitals and social services are now included in the scope of application of the Decision. Moreover, within the 2011 Decision a set of healthcare services are included in a block-exemption which means that the aid involved does not need to be notified to the Commission, based on article 106(3) TFEU\textsuperscript{141}. This declines the power of the Commission to decide on whether an aid could be compatible within the internal market. Besides, the block-exemption Regulation does not provide a threshold for compensation of SGEI in the healthcare sector.

Otherwise, the de minimis Regulation\textsuperscript{142} (adopted in 2012) does provide such a threshold, which contains a maximum amount of €500.000,- compensation (instead of €200.000,-) over three years. Aid below this threshold does not need to be notified to the Commission under article 108(3) TFEU. The revised threshold allows Member States more flexibility to designate SGEI activities, for instance within in the healthcare sector.

\textsuperscript{132} Communication from the Commission on the application of the European Union State aid rules to compensation granted for provision of SGEIs (OJ C 8, 11.01.2012, p. 4-14).
\textsuperscript{134} Commission Decision of 20 December 2011 on the application of Article 106(2) TFEU to State aid in the form of public service compensation granted to certain undertaking entrusted with the operation of SGEI (OJ L 7,11.01.2012, p. 3-10).
\textsuperscript{137} Communication Commission European Union framework for State aid in the form of public service compensation, [2012] OJ C8/15
\textsuperscript{138} Communication from the Commission on the application of the European Union State aid rules to compensation granted for provision of SGEIs (OJ C 8, 11.01.2012, p. 4-14).
\textsuperscript{139} See Joined Cases C-180 to C-184/98 Pavlov and Others.
\textsuperscript{140} Case T-319/99 FENIN [2003] ECR II-357.
\textsuperscript{141} W. Sauter, ‘The impact of EU competition law on national healthcare systems’, 25 August 2012.
The revised Framework applies to compensation of public services which are not included in the Decision. Therefore, the emphasis is particularly on the utility services (such as energy services, transport and electronic communication). Notably, the control on these services has been tightened as there seems to be more scope for liberalization. Moreover, there is less risk of political debate than there would be for social services like healthcare.

A crucial point of the Commission within the revised Decision is the control of overcompensation under article 5(9) TFEU, which benefits the transparency. This means that the amount of compensation of public services obligations shall not be above the sum of the net costs plus the reasonable profit. Although this condition was already there in the 2005 SGEI package, the administrative burden is now reduced by a number of innovations. For instance, a multi-annual approach is included within the 2011 Decision, which means that a provider may receive overcompensation for a certain year, but this must be balanced with the compensation in the remaining period of entrustment. Therefore, an intermediate check on overcompensation should be at least once in three years. In order to check on overcompensation, article 5(9) of the Decision should be taken into account, which prescribes "an internal administration which shows separately the costs and receipts associated with the SGEI and those of other services, as well as the parameters for allocating costs and revenues". This provision concerns "undertakings which carry out activities falling both inside and outside the scope of the SGEI". As we have seen within the IRIS-H Decision of 2009, the Commission mentioned the importance of separate internal administration of commercial and non-commercial activities by the hospitals. This requirement appears to be important within the Commission’s investigation into (incompatible) state aid. However, the actual fulfillment of this obligation by healthcare undertakings appears to be challenging, as SGEI measures are not always accurately defined by the Member State. We will discuss this issue with regard to the Dutch healthcare system in the fourth chapter.

Obviously, the expanded definition of SGEI within the revised SGEI package certainly concerns the healthcare sector, particularly with regard to the liberalization process where the demand of clearly defined SGEI substantially increases. Due to the extension of the SGEI instrument, Member States have more leeway in the financing of their healthcare systems. This could be beneficial as not all healthcare services could be easily linked with a SGEI/Public Service Obligation. Therefore, the national governments could develop a sufficient SGEI policy with regard to their healthcare system. Within this context, the 2011 SGEI package seems to have

143 Commission Decision of 20 December 2011 on the application of Article 106(2) TFEU to State aid in the form of public service compensation granted to certain undertaking entrusted with the operation of SGEI (OJ L 7, 11.01.2012, p. 3-10), article 6(1).
144 Commission Decision of 20 December 2011 on the application of Article 106(2) TFEU to State aid in the form of public service compensation granted to certain undertaking entrusted with the operation of SGEI (OJ L 7, 11.01.2012), article 5(9).
145 Commission Decision of 20 December 2011 on the application of Article 106(2) TFEU to State aid in the form of public service compensation granted to certain undertaking entrusted with the operation of SGEI (OJ L 7, 11.01.2012).
a rather significant impact on the healthcare sector, which is likely to increase in the near future.

3.5 Conclusion

It is unquestionable that the notion of Services of General Economic Interest has a significant role within the healthcare sector. The universal coverage objective of this segment is clearly associated with public service obligations, which could be exempted from the state aid prohibition of article 107(1) TFEU under certain conditions. Here, the IRIS-H Decision of 2009 could be regarded as a useful illustration, which includes the deviation between the application of the Altmark criteria and the 2005 SGEI Package. While the focus of the Altmark criteria is on whether an economic advantage was enjoyed by means of public funding, the SGEI Package leaves out the fourth criterion on efficiency and public procurement. Therefore, with regard to the deficit funding of the IRIS-H by the Belgium state, the underlying costs were no decisive component within the Commission's Decision. The establishment of an efficiency standard remains to be at national level. However, this national flexibility turns out to not be unlimited, as the Court invalidated the Commission’s Decision in the IRIS-H case on 7 November 2012.

With regard to health insurance, the SGEI exemption appeared to be rather useful for compensation with the risk equalization schemes. The BUPA case (2008) exemplified how state aid rules and the Altmark criteria should be applied within the health insurance sector and besides broadened the scope of the universal services. Moreover, the Court made the cost controls more flexible. Notably, this case emphasizes the non-economic approach of the Court with regard to the SGEI exception and the state aid regime. In addition, since the healthcare sector is not harmonized at EU-level, the Court could confirm an -à la carte- application of the Altmark criteria with the BUPA case.

In this context, no clear efficiency test has been established at EU level. Meanwhile, the 2011 SGEI Package includes a expanded definition of SGEI, which substantially broadened the scope of services that constitute SGEI’s with the healthcare sector. Nevertheless, the Commission confirms the necessity of flexibility at national level. Whereas Member States are obligated to designate SGEI missions and PSO, national legislators should clearly indicate which healthcare services have an indispensable purpose within the society. How could this flexible designation of SGEI by Member States and the EU rules on state aid be balanced? Furthermore, what does the generous healthcare exemption under the revised SGEI package mean with regard to the national healthcare policies? Which healthcare services have a rather essential purpose within the society and could be therefore covered by the SGEI concept? To illustrate this issue, the focus of the fourth chapter will be on the role of the SGEI exception within the Dutch healthcare policy.

CHAPTER 4 - THE ROLE OF SGEI WITHIN THE DUTCH HEALTHCARE SYSTEM

As discussed in chapter 1, in a range of previous cases the ECJ concluded that healthcare providers\(^\text{147}\) and – insurers\(^\text{148}\) could be regarded as undertakings if they are engaged in economic activities. Therefore, state intervention in terms of financial benefits to healthcare providers is assumed to be state aid under article 107(1) TFEU. In spite of the disposition that these financial profits could be in consideration of solidarity and universal coverage, Member States are still committed to estimate the significance of the support with regard to the Altmark case\(^\text{149}\). If a financial measure meets all criteria of this judgment, it will be exempted from the notification procedure under the standstill provision of article 108(3) TFEU. However, where the conditions for the application of article 107(1) TFEU are not fulfilled and in case the Altmark exception does not apply, there is still is an escape path: a designation as SGEI under article 106(2) TFEU as far as the state measure could be regarded as accomplishing a public service task.

As we have seen in the IRIS-H Decision\(^\text{150}\) and the BUPA case\(^\text{151}\), the SGEI exception could have a significant impact on the healthcare (insurance) sector\(^\text{152}\). In this chapter, the focus will be more on the actual healthcare services. However this subject appears to be political sensitive, as there are conflicting interests of various parties involved. For instance, hospital mergers are unprofitable for consumers concerning the ‘human scale’ of activities and could besides lead to detrimental consequences of market power\(^\text{153}\). Moreover the considerable role of public interests related to healthcare makes it unclear whether this sector falls within the ambit of the competition policy framework. Therefore, the concept of SGEI turns out to be very useful to confine the problems with market failures within healthcare markets. The Commission’s White Paper of 2004 affirmed that healthcare services could be assumed as part of SGEI\(^\text{154}\), but health services were enclosed by a separate communication which focus was less on SGEI.\(^\text{155}\)Following the latter, market harmonization measures have been introduced by means of the Patient’s right directive, in order to address issues concerning cross border healthcare\(^\text{156}\).

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\(^{149}\) Case C-280/00, Altmark [2003] ECR 1-7747


\(^{152}\) GC Case T-289/03 BUPA v. Commission [2008] ECR II-81; Case C-280/00, Altmark [2003] ECR 1-7747


\(^{155}\) Consultation regarding Community action on health services, SEC(2006) 1195/4

Within this chapter the involvement of EU State Aid law and the SGEI exception within the national healthcare system will be determined. The Dutch healthcare system will be a useful illustration of the application of the SGEI instrument within the healthcare sector, as the Dutch healthcare system is basically market-driven which means that it exclusively includes private healthcare insurers and private healthcare providers.

We will discuss the role of the NZa with regard to the SGEI instrument within the Dutch healthcare policy within this chapter.

So far, we have debated the position of the SGEI exception within the healthcare sector. Within this fourth chapter on the following set of questions will be answered:

- What were the leading aspects of the healthcare liberalization in the Netherlands and the transformation of the Dutch healthcare policy?
- Which impact has this liberalization on the application of the SGEI exception within the current Dutch healthcare system?
- How is the SGEI concept developing within the Dutch healthcare system?
- How will the Dutch SGEI policy within healthcare relates to the 2011 SGEI package?

Finally and against this background, the conformity of the current SGEI policy within the Dutch healthcare sector and the EU state aid rules will be outlined in the conclusion.

### 4.1 Liberalization of the Dutch healthcare system

Between 1940 and 1970 the emphasis of the Dutch healthcare policy was to ensure universal coverage. Apparently this objective was not feasible as healthcare expenses increased to untenable levels. As a consequence, the government reformed its policy. The introduction of controls, distribution and compensation caps within 1970 to 2000 were indicating a change to a cost containment approach. Nevertheless, the government changed its policy, since the healthcare expenses were untenable increasing. Furthermore, the introduction of market elements became more important within the provision of public services. As cost containment appeared not to be an effective solution, a shift found place to incentive-based renewals in 2000\(^{157}\). Consequently, free consumer choice could be assumed as the strength behind this liberalization process. The presumption came into being, that a competitive market based on free consumer choice, could guarantee the highest level of efficiency of healthcare. Free choice of healthcare insurance will evolve into a vibrant competitive insurance market which leads to selecting contracting between provider and insurer\(^{158}\). This means that consumers, providers

\[157\] M. Varkevisser, 'Patient choice, Competition and Antitrust Enforcement in Dutch Hospital Markets', Erasmus Universiteit; Rotterdam, 2010.

and insurers are able to adapt to each other within a ‘healthcare triangle’\(^{159}\). Based on this innovative demand driven approach, the private health insurers could be regarded as the engine of competition\(^{160}\). Consequently, this is beneficial for the costs, but as well for the quality of healthcare. As we have seen with regard to risk equalization, not all healthcare services are appropriate to be included in the competitive insurance market. Therefore, in some cases compensation (of SGEI activities) by public resources within the healthcare system is desirable.

However, the desire of competition within the healthcare sector resulted in a market-oriented healthcare reform by means of the implementation of the Health insurance act (Zvw) of 2005. Through a mandatory health insurance scheme, the position of Dutch citizens could be better protected. This scheme supports open enrollment, which enables individual consumers to choose between private insurers, who could shape their basic health plans by establishing differentiated contracts or collaboration with healthcare providers\(^{161}\). The latest is described as the ‘purchasing or agency role’ of insures, which will benefit the quality and price of healthcare\(^{162}\).

As during the years, the healthcare system could not guarantee a solid representation of the public interest within the competition policy, the Healthcare Market Organization act (WMG) was adopted on 1 October 2006. The introduction of the WMG could be seen as an element within the entire revision of the healthcare system. Central within this development, has been the establishment of the Dutch Healthcare Authority (NZa), which is exclusively competent to enforce the sector-specific competition policy for healthcare. The NZa strives for dynamic competition within the market structure, in particular to guarantee market entry. Interestingly, both a general – and sector specific competition policy monitor the market organization within the Dutch healthcare system. Therefore, the cooperation between the NMa (which is responsible for the enforcement of EU competition law in the Dutch market, based on article 101 and 102 TFEU) and the NZa is included in article 17 of the Healthcare Market WMG. In case of overlapping competences of the NMa and the NZa within the healthcare sector, the NZa takes precedence.

Although the Minister of Health, Welfare and Sport is taking the most important decisions, the NZa could be seen as the supervisory body of the WMG. By giving advice to the Minister, the NZa monitors the quality, accessibility and affordability of healthcare on behalf of the consumer interest. Within the revised and liberalized healthcare market, regulation by a centralized system did not contribute to a well-functioning and effective healthcare sector,


\(^{160}\) W. Sauter, ‘Risk equalization in health insurance and the new standard for public service compensation in the context of state aid and services of general economic interest under EU law’, TILEC, November 2008.

\(^{161}\) M. Varkevisser, ‘Patient choice, Competition and Antitrust Enforcement in Dutch Hospital Markets’, Erasmus Universiteit; Rotterdam, 2010.

which has been the incentive to adjust legislation on the matter. This resulted in a deregulation of prices within a part of the healthcare sector (around 10% deregulated rates in the Dutch coalition agreement of 2007 which grew by 20% in 2008 and for now by 70%). The emphasis was now on initiatives and liability of healthcare providers and insurers. The WMG contents provisions to reach an efficient framework of care, cost control and the protection and improvement of the position of the consumer\(^\text{163}\).

In addition, developments were also taking place on the provision side. Although the reform of the Dutch insurance market with the Health insurance act can be seen as the most tangible so far, also the healthcare provider markets became subject of the market-oriented healthcare innovations. Competition within these provider markets is encouraged by the freedom of negotiation between insurers and providers on prices/quality of healthcare. Furthermore consumer behavior is an important factor in the promotion of competition within this sector, with respect to their active selection between individual healthcare providers in order to create consumer-driven healthcare\(^\text{164}\). Ultimately, the objective of this reform should be the provision of “quality, innovative power, efficiency and affordability” of healthcare\(^\text{165}\).

Increasing prices of hospital care gives rise to the introduction a system of performance-based funding (since the implementation of the Health insurance act in 2006) within the healthcare market, which enables negotiations between healthcare providers and healthcare insurers. Consequently, hospitals and healthcare insurers are able to negotiate on the prices and quality of care. Notably, performance-based funding and competition are interrelated. This enforces the approach of hospitals being undertakings on the healthcare market\(^\text{166}\). Central within the performance-based funding, is the connection between diagnosis and treatment (the so-called DBC financing). This DBC financing was introduced to encourage healthcare innovation, efficiency and transparency with regard to the contracting of hospitals by healthcare insurers\(^\text{167}\).

In January 2012, the considerable number of DBC-financed products appeared to be counter-productive and the DBC financing system has been changed into the DOT-system. Consequently, the focus of the hospital funding is now on treatment rather than the medical specialist\(^\text{168}\), which increases the clarity of purchasing healthcare. However, this means that the insurer must effectively counteract the necessity of the number of treatments with regard to the healthcare obligation\(^\text{169}\). In addition, the free pricing segment (B-segment) of hospital


\(^{164}\) M. Varkevisser, ‘Patient choice, Competition and Antitrust Enforcement in Dutch Hospital Markets’, Erasmus Universiteit; Rotterdam, 2010.


\(^{168}\) ‘Separating fact from fiction’, Annual statement of the Dutch healthcare system 2012, Dutch healthcare Authority NZa.

\(^{169}\) ‘Separating fact from fiction’, Annual statement of the Dutch healthcare system 2012, Dutch healthcare Authority NZa.
care was increased to 70%, the idea behind price competition is that it would lead to negotiations on the best possible care for the most satisfactory price. So far, a number of types of care have been excluded from the performance-based funding. Fixed maximum rates apply to these types of care (indexed by the NZa), which are included in the A-segment. Apart from this A and B-segment, performance-based funding is not desirable for various types of healthcare which are closely related with the public interest\textsuperscript{170}. Therefore, the continuity of these types of care should be guaranteed by means of a (partly) fixed compensation. This funding takes place by the so-called ‘availability contribution’ (beschikbaarheidbijdrage) under the Dutch SGEI regime which will be examined at a further stage of this chapter.

In brief, the Dutch healthcare sector is involved in a period of transformation. Instead of a system with a centralized regulation by the national state based on general interests, the current market is grounded on negotiations between insurers and providers of healthcare. Moreover, the merits of both parties are now directly related to the performance of the healthcare providers, which extends the financial risks. Therefore, only the most efficient insurers and providers will survive, which is beneficial for the functioning of the healthcare system as a whole\textsuperscript{171}. With regard to the protection of consumers, the NZa is in charge of regular duties in this sector, to guarantee a fair and well-functioning healthcare provision.

\section*{4.2 The role of SGEI within the Dutch healthcare system}

As was discussed in the first chapter, based on the ‘undertaking-approach’ within the EU state aid rules, financial support to healthcare providers and healthcare insurers by the state is not accepted\textsuperscript{172}. However by the application of the SGEI-exception, this general rule could be justified if a public interest or the continuity of care comes into play, in the sense of essential elements of care.

So far, there are no definite objective criteria under EU law and Dutch legislation in order to provide compatible state aid by means of SGEI, which leads to a case-by-case interpretation by the Member States\textsuperscript{173}. With regard to the Dutch healthcare policy, this task does not fall within the competences of the NZa, but appears to be a rather political decision (by the Minister of Health, Welfare and Sport). However, the NZa can give (un)requested advice, which may be a decisive factor. With respect to the current healthcare system, it seems extremely important that SGEI standards will be legally confirmed in order to prevent unjustified allocation of essential care. Essentially, insurers have a duty of care grounded on the Healthcare insurance act (Zvw) and the General act Extraordinary Healthcare costs

\textsuperscript{170} ‘Invoering prestatiebekostiging medisch specialistische zorg’, reacties op consultatiedocument, Nederlandse zorgautoriteit, juli 2011.
\textsuperscript{171} ‘Zorgaanbieders met financiële problemen in het nieuwe zorgstelsel; early warning system en mogelijkheden voor steunverlening’, Advies Nederlandse Zorgautoriteit, Juni 2009.
\textsuperscript{172} Case 437/09 AG2R Prévoyance v Beaudout Père et Fils SARL and Joined Cases C-180/98 to C-184/98 Pavel Pavlov and Others v Stichting Penioenfonds Medische Specialisten [2000] ECR 1-6451 at par 75.
(ZWBZ). However, considering the regulated competition within the healthcare market and the
consumer's free choice of healthcare providers acting as undertakings in an economic context,
the best method to address this essential care is by the application of the SGEI exemption.

Therefore, the focus should be on the service (treatment) rather than on the providers
medical specialists) that accomplished the actual care. As we have seen, healthcare
services are included in a block-exemption and therefore notification to the Commission is not
necessarily needed. A certain degree of state involvement is required to guarantee the
continuity and availability of care when the stability of the market is distorted (market
failures). Here, the SGEI exception could be a useful instrument as, according to EU state aid
law and the Dutch Competition Act (Mw), SGEI do not fall within the scope of the general
prohibition of state intervention. However, state aid could only be exempted under article
106(2) TFEU if strict criteria are met.

So far, there are very few examples of SGEI within the Dutch healthcare system. As we have
seen in the third chapter, in 2005 the European Commission has decided that the basic
insurance within the Dutch healthcare system could fall within the scope of the SGEI
exception. Moreover, the Dutch risk equalization scheme was considered as a proportional
restriction of competition in order to guarantee the basic insurance, even though there was no
explicit indication of the SGEI exception.

An other interesting illustration of this narrow scope, is the case around the state aid request
by the 'Ijsselmeer-hospitals' (2009). So far, this request concerned the highest amount of
compensation to the NZa ever. The hospitals were claiming they should receive an amount of
29,5 million euro compensation, in order to guarantee the continuity of the healthcare within
the area concerned. Although the NZa confirmed this problem of continuity, the application of
the hospitals was lacking a solid basis. Consequently, the NZa decided not to grant the
request. However, the NZa finally approved a second application by the Ijsselmeer-hospitals,
including a request for an amount of 18 million which was grounded on a more reasonable
future representation with regard to the continuity of acute and chronic care provision and
the appropriate fundamental facilities concerned. However, within this case there was no
explicit indication of the SGEI exception. In my opinion, the latter is more likely the result
from the inexperience of the NZa and the Minster of Health, Welfare and Sport concerning the

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174 ‘Zorgaanbieders met financiële problemen in het nieuwe zorgstelsel; early warning system en
mogelijkheden voor steunverlening’, Advies Nederlandse Zorgautoriteit, Juni 2009.
175 Commission Decision of 20 December 2011 on the application of Article 106(2) of the Treaty on the
176 ‘Zorgaanbieders met financiële problemen in het nieuwe zorgstelsel; early warning system en
mogelijkheden voor steunverlening’, Advies Nederlandse Zorgautoriteit, Juni 2009.
179 Included in: beleidsregel Steunverlening aan instellingen met financiële problemen.
180 NZa-Besluit inzake de aanvraag om steunverlening ten behoeve van de Stichting
Ijsselmeerziekenhuizen, Nederlandse Zorgautoriteit, 2 februari 2009.
2009/6, p.219; W. Sauter & M.F.M. Canoy, ‘Ziekenhuisfusies en publieke belangen, Markt en
designation of the SGEI concept. However, the situation has changed since the introduction of the availability contribution as a compensation of SGEI within the Dutch healthcare system, which will be discussed in the next paragraph.

Nevertheless, the application of the SGEI exception within the Dutch healthcare sector have become rather important with regard to compensation for indispensable services. As already mentioned, this could confine problems that appeared since the deregulated rates within the healthcare market. Various types of care could be exempted from the state aid prohibition of article 107(1) TFEU as performance-based funding could possibly have an adverse effect on the availability and continuity of care. However, the application of SGEI within the Dutch healthcare sector appears to be in line with the *Altmark* criteria. The SGEI exception still remains a flexible instrument, which could be broadly interpreted by the national states. The question raises whether it is desirable to set a strict definition of the concept at national level, in order to make the use of the SGEI exception more efficient. This concern will be discussed in a further stage of this chapter, as the discussion on the scope of SGEI with regard to healthcare services appears to be crucial within the Dutch SGEI-policy.

### 4.3 The availability contribution as compensation of SGEI within the Dutch healthcare system

Within the Dutch healthcare policy, the continuity and availability of certain types of health care remains to be an important element within the deliberation on the SGEI exception. Recently in 2012 various modifications within the content of the WMG were applied, as a result of the removal of the budget financing of hospitals. Subsequently, this has consequences for the financing of numerous healthcare services. Due to this development, various services of healthcare providers require separate funding, as it is not possible and/or desirable to assign these costs to consumers. The services concerned rely on specific medical specialists or special facilities in order to guarantee their availability. For instance, this could be related to the accessibility of healthcare services within a certain time period in urgent situations. Therefore, these types of care may be compensated by means of the availability contribution, an instrument which is included in the WMG on 1 January 2012. This compensation is paid by public funds in order to respond to the duty of care of the insurers.

Notably, services which could be compensated with the availability contribution should be recognized and justified by a general measure of governance (AmvB)\(^\text{182}\). Subsequently, the NZa could provide the availability contribution as compensation of SGEI under article 106(2) TFEU. The contribution could also apply to compensation of non-economic Services of General Interest, but we will focus on SGEI. Grounded on article 56a (7) WMG, the Minister of Health, Welfare and Sport could also put healthcare providers in charge with a SGEI. Compensation of

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\(^{182}\) MC-U-3114938, Toepassing instrument beschikbaarheidsbijdrage WMG, Ministerie van Volksgezondheid, Welzijn en Sport, 25 mei 2012.
this SGEI by the availability contribution should guarantee the availability of healthcare under article 2 WMG\(^{183}\) (Healthcare market organization Act).

In a first stage, services of healthcare providers which are eligible for compensation by the availability contribution should be determined. Under article 56a WMG, the NZa could allocate the availability contribution to healthcare providers for the purpose of the availability of the indicated types of healthcare services (justified by a general measure of government). To achieve this availability objective, healthcare providers could receive a compensation of activities and facilities, of which:

- It is not desirable to charge consumers or insurers for the costs of each individual performance;
- Charging the costs to tariffs will be an interference with the healthcare market;
- Will not be financed somehow.

To apply the compensation, the NZa could act either by an application of the health insurers /healthcare providers concerned, or by own-initiative\(^{184}\). However, under article 59e and Article 7 WMG, the NZa is always dependent on an instruction of the Minister of Health, Welfare and Sport, which includes the parameters for the amounts as well as the pre-conditions of the availability contribution.

In a second stage, decisions on which providers receive the contribution, on which amount and on the duration will be included in a policy guideline. Therefore, the NZa is able to allocate this remuneration to care providers in two ways: by existing designation for the year 2012 and by a new designation of the availability contribution for the year 2013 under article 57(1) e WMG. Who has got financial support in 2011, will receive the same amount of availability contribution for the year 2012. This classification is more and less grounded on historical foundations, as for the year 2012 there was no appropriate delamination of the types of care which could be compensated with an availability contribution. Policy guideline BR/CU-2063\(^{185}\) is particularly intended to regulate the financing of these healthcare performances which are designated as SG(E)I by the Minster of health, Welfare and Sport. This policy guideline became effective since 1 January 2012 and will expire on 1 January 2013. In the meantime, For the year 2013, the Minister of Health, Welfare and Sport has requested the NZa on 18 January 2012 to publish a recommendation on the definition and delimitation of three types of care: post mortem donation of organs, care provision by mobilized medical teams and specialized burns

\(^{183}\) Wet van 7 juli 2006, houdende regels inzake marktordening, doelmatigheid en beheerste kostenontwikkeling op het gebied van de gezondheidszorg (Wet marktordening gezondheidszorg).

\(^{184}\) Besluit 396, houdende aanwijzing van de vormen van zorg die in aanmerking kunnen komen voor een beschikbaarheidsbijdrage op grond van de Wet marktordening gezondheidszorg en enkele wijzigingen in het Besluit uitbreiding en beperking werkingsfeer WMG (Besluit beschikbaarheidsbijdrage WMG).

\(^{185}\) Beleidsregel BR/CU-2063, Beleidsregel Beschikbaarheidsbijdrage, Nederlandse Zorgautoriteit, 2012.
These types of care will be compensated by new investigation on the costs and facilities instead of copying the 2011 situation, in order to avoid overcompensation. An additional policy guideline will indicate the availability contribution for healthcare providers which already received compensation of public service costs in 2012. Through these guidelines of the NZa, the Minister can establish a definitive delimitation within a Ministerial Decree that will be published in 2013. Which organizations will receive a financial support will be also determined within this guideline, as well as the amount of this availability contribution. The latter could be determined based on either normative or genuine parameters.

As we have seen, the amount of compensation by the state should not be higher than absolutely necessary to provide the service concerned. The same must apply for the availability contribution. To avoid overcompensation and cross-subsidization, healthcare providers are obliged to give an indication of the sum of net costs plus the reasonable profit by an accurate administration (article 36 WMG). Non-SGEI services and SGEI services should be recorded separately when the undertaking does not exclusively exercise SGEI.

As the availability contribution is granted in the form of deposits, the determination of the actual amount will be after a year in which the healthcare undertaking has received availability contribution.

The above mentioned condition of separate administration originates from article 1 of the Transparency Directive. Since the availability contribution is grounded on the SGEI exception on the EU state aid prohibition under article 107(1) TFEU, we must follow the EU state aid rules. To what extent are these rules incorporated within the Dutch healthcare policy? How does the national freedom to interpretation SGEI affect the designation of the availability contribution? In order to discuss the conformity of the EU state aid rules and the Dutch policy, we will finally examine whether the availability contribution is in accordance with the 2011 SGEI package.

4.4 The availability contribution within the scope of the 2011 SGEI package

At this stage, it is clear that state intervention within the national healthcare system must be compatible with EU state aid law. It appears that the European rules are based on the principles admitted in the current NZa policy. As an exception on the prohibition of state aid, the SGEI exception can be found in European legislation (article 106(2) TFEU) but is also defined within the Dutch Competition act (e.g. article 11 Mw). Within the EU SGEI policy and the Dutch SGEI policy, the availability and continuity of the type of care is decisive within the determination whether the financial support to a healthcare undertaking could be seen as a

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186 Advies Afbakening zorg beschikbaarheidsbijdrage, zorg bij post mortem orgaanuitname bij donoren, zorg door mobiele medische team en gespecialiseerde brandwondenzorg, Nederlandse Zorgautoriteit, februari 2012.


188 Besluit 396, houdende aanwijzing van de vormen van zorg die in aanmerking kunnen komen voor een beschikbaarheidsbijdrage op grond van de Wet markordering gezondheidszorg en enkele wijzigingen in het Besluit uitbreiding en beperking werkungsfeer WMG (Besluit beschikbaarheidsbijdrage WMG), titel 4.3.
SGEI\textsuperscript{189}. Moreover, the requirement of separate internal administration is on both levels important to decrease the opportunity of overcompensation between SGEI to non SGEI activities.

Within the Dutch policy, the availability contribution concerns a subsidy under the Dutch 'Administrating Law' (article 4:21 Awb). Therefore, the establishment and the allocation of the availability contribution must be based on title 4.2 of this Act, which is also in conformity with the EU state aid rules\textsuperscript{190}.

We have seen that the 2011 SGEI package\textsuperscript{191} includes an expanded definition of (social) SGEI. This could be considered as an important advantage for the healthcare sector, which is complemented by the extension of the scope of application of the Block Exemption Decision. Consequently, compensation of SGEI activities within the healthcare sector should not necessarily be notified to the Commission. As the availability contribution falls within the scope of application of this Decision (as it frequently constitutes a compensation of SGEI activities), the same must apply to the availability contribution.

As an element of the 2011 SGEI package, the \textit{de minimus} Regulation (final text of 2012)\textsuperscript{192} provides that a maximum amount of €500.000,- compensation over three years does not need to be notified to the Commission. Notably, the Altmark criteria are not included in this Regulation. The revised threshold involves more flexibility with regard to the designation of SGEI by Member States and thus the allocation of the availability contribution within the Dutch healthcare system. It is questionable whether this will benefit the transparency of the SGEI regime within the future, as activities could be easily (and unjustified) classified as SGEI and thus compensated with an availability contribution if the amount of compensation is below the threshold of €500.000,- over three years.

Besides, there are more criticisms with regard to the flexibility of Member States to designate SGEI. As we have discussed, national courts are empowered to decide on compatible aid as well as on the application of a block exemption\textsuperscript{193}. Consequently, an open and transparent SGEI policy at EU level is not guaranteed as each national government could have its own SGEI policy. Here, a useful illustration is the above-mentioned internal administration of the availability contribution, which causes lots of discussion. The healthcare functions which receive an availability contribution, are mostly not clearly delimited by the Dutch Minister of

\textsuperscript{189}‘Zorgaanbieders met financiële problemen in het nieuwe zorgstelsel; early warning system en mogelijkheden voor steunverlening’, Advies Nederlands Zorgautoriteit, Juni 2009.

\textsuperscript{190}Besluit 396, houdende aanwijzing van de vormen van zorg die in aanmerking kunnen komen voor een beschikbaarheidsbijdrage op grond van de Wet marktregulering gezondheidszorg en enkele wijzigingen in het Besluit uitbreiding en beperking werkingssfeer WMG (Besluit beschikbaarheidsbijdrage WMG).

\textsuperscript{191}Commission Decision of 20 December 2011 on the application of Article 106(2) TFEU to State aid in the form of public service compensation granted to certain undertaking entrusted with the operation of SGEI (OJ L 7, 11.01.2012, p. 3-10).


\textsuperscript{193}Commission notice on the enforcement of State aid law by national courts, OJ 2009 C85/1.
Health, Welfare and Sport. Therefore, it is often not clear which amount of the internal administration is directly connected with the compensation. Consequently, national control on cross subsidization of commercial activities and thus overcompensation is barely conceivable. It seems paradoxical that on the one hand the 2011 SGEI package aims to reduce the administrative burden, but on the other hand the opposite seems to appear when SGEI functions within the healthcare sector are not clearly defined by the Member States. Having an internal administration of SGEI activities which are not delimited seems even more burdensome for healthcare undertakings.

So far, the delimitation of the types of care (designated as SGEI) which could be compensated with the availability contribution seems to be most problematic. If it is not clear which facilities and how many medical specialists are necessary to keep the care provision available, it is almost impossible for the NZa to allocate an availability contribution based on genuine costs. Moreover if there is no strict definition of the contribution, the Minster of Health, Welfare and Sport can easily designate an availability contribution to each possible service whenever it suits.

Against this background, it is questionable whether the availability contribution is entirely conform to article 5(9) of the Decision\textsuperscript{194} and therefore with the 2011 SGEI-package.

\subsection*{4.5 Conclusion}

As discussed above, within the healthcare liberalization in the Netherlands the focus is on free consumer choice which should eventually lead to increased efficiency of healthcare. Therefore, both healthcare insurers and healthcare providers are subject of market-oriented modernizations. To support the development, organization and monitoring of the healthcare market, the in 2006 adopted WMG includes provisions to guarantee the efficiency of care, the position of the consumer and cost control. Within this context, the NZa is responsible for the market monitoring with regard to the healthcare providence - and healthcare insurance market. Furthermore, the NZa is responsible for the protection of the coherence within this sector-specific competition policy and its consistency with general competition policy concerning the interpretation of key concepts like market power and market dominance.

With the introduction of performance-based funding of the Dutch healthcare system in 2006, there is more room for competition, which enables negotiations between healthcare providers and health insurers on the price and quality of healthcare.

\textsuperscript{194} Commission Decision of 20 December 2011 on the application of Article 106(2) TFEU to State aid in the form of public service compensation granted to certain undertaking entrusted with the operation of SGEI (OJ L 7,11.01.2012, p. 3-10).
Based on the broader scope of application within the 2011 SGEI Decision, healthcare is the subject of a more flexible SGEI regime under the block exemption regulation and the \textit{de minimus} Regulation. On the one hand, the national state has much room to interpret the SGEI exception and therefore to allocate the availability contribution within the healthcare system. Consequently, in the Dutch healthcare system SGEI activities which should not be included within the current performance-based funding could be compensated with this availability contribution. In this context, the availability contribution under article 56(a) WMG could have a significant role within the future in ensuring public services, considering the deregulation of the Dutch healthcare market.

On the other hand, the question remains whether the flexible approach towards SGEI within the healthcare sector in the 2011 SGEI package benefits the accomplishment of the exception on state aid under article 107(1) TFEU.

It is doubtful whether the Dutch healthcare system could comply with the EU state aid rules, especially with regard to the control on overcompensation (and cross subsidization of non SGEI activities). Because a missing strict delimitation of SGEI activities which could be compensated with the availability contribution, it is difficult for healthcare undertakings to meet the requirement of separate accounts of SGEI and non SGEI activities. This will be especially problematic for healthcare undertakings which received financial support in 2011 and therefore the availability contribution in 2012 (and 2013).

Finally, we have seen that the flexibility of Member States to designate SGEI has been increased within the revised 2011 SGEI package. Within the struggle to apply the SGEI exception within the Dutch healthcare systems, the availability contribution is a reasonable attempt to strike a balance between the social services objectives and the deregulation of the healthcare system. However, it is questionable whether the national freedom to designate SGEI will not facilitate the transparency within the SGEI regime. The risk of unjustified designation of SGEI healthcare activities which should be compensated by the availability contribution by the national state is not unthinkable. Paradoxically, the deregulation of the Dutch healthcare system seems to require clearer and possibly stricter rules on the definition of SGEI in order to achieve a transparent national SGEI regime which is in line with the 2011 SGEI package at EU level.
CONCLUSION

Having looked at the EU state aid rules, the EU SGEI regime and their impact on the (Dutch) healthcare sector, a number of conclusions could be drawn with regard to the central question of this research:

What is the impact of the application of European State Aid rules on the healthcare sector and what is the actual effect of the Services of General Economic Interest exception on the Dutch healthcare system?

So far, the influence of EU competition and state aid law in the national healthcare system is not really visible. As we have discussed, the organization of healthcare is a national task and European intervention within this sector appears to be a politically sensitive issue. As there is no harmonization of healthcare policy at EU-level, the national state has a significant influence on the price, quality and accessibility of healthcare, based on article 168(7) TFEU. With regard to the public policy objectives within this sector, mainly EU state aid rules are difficult to combine with the Member States’ responsibilities for their healthcare policy. Therefore, harmonization of healthcare at EU level is certainly no popular subject.

However, the role of EU state aid law within the healthcare sector should not be underestimated. Although the national courts are enabled to decide whether a measure could be classified as state aid, the Commission reserves the exclusive power to give clearance to declare aid compatible with the internal market. In Pavlov as well as in the Ambulanz Glöckner case is determined that if an entity is engaged in an economic activity in the meaning of providing goods and services for economic consideration, EU state aid rules are applicable. It appears that most healthcare providers fall into that scope and could therefore be classified as undertakings. As we have seen there is a conflict between this approach and the principle of solidarity with regard to the provision of healthcare insurance. Remarkably, this struggle resulted in two different approaches to determine whether the restrictions on competition were compatible with the internal market. In cases such as FENIN, Bettercare II and AOK, is determined that the entities concerned were not caught by EU state aid law because they were not undertakings but were grounded on the principle of solidarity. Conversely, a few years later, the Commission declared the Dutch risk equalization scheme involving health insurers that were undertakings compatible with the EU state aid rules, but this time under the heading of the SGEI exception. This is remarkable because both AOK as well as the Dutch risk equalization case related to a risk equalization system and the facts involved were very similar.

As we have seen in BUPA and the Dutch risk equalization case, the SGEI exception has a rather significant role with regard to compensation with risk equalization schemes.

Concerning competition within the healthcare market, we have seen that the SGEI instrument provides the most valuable exception to the state aid prohibition under article 107(1) TFEU. Member States are allowed much flexibility as the SGEI instrument could be designed at national level. However, the Altmark criteria (except for the fourth criterion of efficiency) which are adopted in the 2005 SGEI package and the principle of proportionality, must be taken into consideration. Furthermore, the Commission reserves a certain power to control on overcompensation.

It is unquestionable that the SGEI instrument has a significant impact on the national healthcare systems, since the 2011 SGEI package has broadened the scope of application of the SGEI instrument, particularly with regard to the healthcare sector. This sector has become subject of a more flexible SGEI regime under the revised block exemption regulation, but as well under the de minimus regulation. Notably, national Courts are entitled to determine the application of a block exemption. Furthermore, the revised Communication and Decision have been innovative developments within the 2011 SGEI package, which include more clarity on some fundamentals of SGEI. Although the scope of the freedom to designate SGEI by Member States is certainly not clear, the extension of the SGEI instrument creates more room for a national healthcare policy grounded on public services objectives.

With regard to the Dutch healthcare, the government protects the public interest within a system of ‘regulated competition’. Since the introduction of the performance-based funding and the market-oriented healthcare reform in 2006, there has been more room for competition which benefits the negotiations between health insurers and healthcare providers on the quality and price of healthcare services. However, not for all healthcare services it is possible and/or desirable to be subject of this selective contracting. This problem exists, for example, if the service concerned relies on a specific medical specialist or special facilities in order to guarantee their availability. Therefore, these services would be considered for compensation by the availability contribution from public funds under article 56a WMG.

Obviously, the impact of EU state aid law on the application of SGEI exception within the Dutch healthcare system is noticeable. Particularly noticeable is the control on overcompensation and the separate administration of SGEI activities and non-SGEI activities by healthcare undertakings within the policy on availability contribution.

It should be noted that the application of the SGEI instrument with the availability contribution in the Dutch healthcare system is in the development stage. Until 2012, the availability contribution has been designated on historical foundations, as there was no suitable delimitation of the types of care which could be compensated by an availability contribution. For 2013, the NZa can allocate the remuneration to healthcare providers on demand under
article 57(1)e WMG. Consequently, a new investigation on the costs and required facilities for types of care concerned is needed, in order to comply with the EU state aid rules on overcompensation. However, there are no strict rules under both EU law and Dutch law on which types of care could benefit from the SGEI exception and thus receive compensation of costs related to their public service obligation. Therefore, the risk of unjustified allocation of the availability contribution within the Dutch healthcare system remains, as the NZa does not have a clear legal framework. Consequently, the Commission could intervene by means of declaring the state aid concerned incompatible with the EU internal market. Paradoxically, stricter requirements of the definition of SGEI could prevent this will happen. However, the question remains how more SGEI regulation could fit in a liberalized and deregulated Dutch healthcare market. Perhaps this could be a question for future research.
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