

COMPETITION LAW AND THE FUNDING OF EU HOSPITAL SERVICES

DISTORTIVE EFFECTS OF COMMISSION DECISION 2005/842

1. THE PURPOSE OF THIS PAPER

- [1] This paper is submitted on behalf of the European Union of Private Hospitals (“**UEHP**”). UEHP is the European association of the private hospital industry. Its members include national associations bringing together hundreds of private hospitals across the EU: UEHP represents over 4,470 hospitals, providing a total of 756,000 beds and employing almost 1,150,000 people. UEHP therefore represents a significant proportion of those parties who are operating in the European hospital sector.
- [2] We are submitting this paper in connection with the European Commission (the “**Commission**”) review of Commission Decision 2005/842¹ (the “**2005 Decision**”). The 2005 Decision exempted funding to public hospitals, which does not fulfil the *Altmark* criteria², from State aid notification. UEHP believes that the 2005 Decision thereby causes serious distortion of competition in the health sector, which has a negative impact on both consumer welfare and Member State budgets.
- [3] This paper follows previous contact between UEHP and the Commission, including a meeting on 21 April 2008 with: Ms Rodriguez Gallindo, Chief of Unit; Ms Sinnæve, Deputy Chief of Unit; Ms Gueneau De Mussy, Case Officer; and Mr Holzleitner, Policy Officer. The paper is submitted in the context of the public consultation on State aid and SGEIs, for which UEHP and two of its member associations (the French *Fédération Hospitalière Privée*, “**FHP**”, and the French association of private psychiatric clinics, “**UNCPSY**”) provided comments, and the Commission’s assessment of the impact of the 2005 Decision on the internal market.
- [4] The purpose of this paper is to:
- Provide an overview of UEHP’s principal concerns regarding competition in the internal market for healthcare, and in particular the distortion of competition associated with the funding of public hospitals following the 2005 Decision;
 - Provide a review of complaints that UEHP’s national member associations have previously submitted to the Commission, as evidence of this long standing, pan-European problem;
 - Provide an update regarding developments since UEHP’s meeting with the Commission in 2008, showing current examples of distortion in the internal market for healthcare;
 - Urge the Commission to take appropriate steps to address these concerns;

¹ 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, OJ L 312, 29.11.2005, p.67.

² *Altmark Trans GmbH and Regierungspräsidium Magdeburg v Nahverkehrsgesellschaft Altmark GmbH* (2003) ECR I-7747.

- Propose a constructive solution to develop an improved financing system that is compliant with the principles of EU law;
- Show UEHP's commitment to assisting the Commission in this process; and
- Request the Commission to provide UEHP with documents and information that can support its involvement in reforms of the sector to the benefit of European consumers and patients.

[5] In Section 7 of this paper, below, UEHP has submitted certain proposals for changes in the implementation of the 2005 Decision, and changes to the 2005 Decision itself. To summarise, the proposals are as follows:

- Improve transparency by enforcing the requirement that beneficiaries of State funding maintain separate accounts for their SGEI and non-SGEI activities;
- Control overcompensation by ensuring that Member States properly check that beneficiaries do not receive payments in excess of the cost of performing their SGEIs, and that any overcompensation they do receive is repaid;
- Permit effective monitoring by requiring all Member States to submit to the Commission detailed and verifiable reports on their implementation of the 2005 Decision;
- Remove the existing block exemption on the notification of State aid to hospitals, or at least introduce a ceiling above which notification is required (following a thorough impact assessment of the negative consequences of the existing system in the internal market); and
- Adopt suitable guidance on specific issues regarding the implementation of the 2005 Decision in the context of funding to hospitals, including the creation of an entrustment register.

2. ABSTRACT

[6] Throughout the EU, competition is distorted in the market for the provision of hospital services, in particular by the State funding provided to hospitals and the basis on which this funding is allocated.

[7] In many countries, publicly-funded and privately-funded hospitals exist side-by-side and perform the same services, including Services of General Economic Interest ("**SGEIs**").

[8] However, despite being entrusted to perform the same services, the allocation of funding to each is not calculated consistently. Public hospitals receive amounts of funding that do not appear to be proportionate to the costs of the services they provide, allowing for over-compensation and cross-subsidisation. In many cases, also, the State compensates public hospitals for their end of year deficits, regardless of the amount.

[9] State funding to public hospitals typically does not fulfil the *Altmark* criteria, and hence it constitutes State aid. In general, the fourth *Altmark* criterion is not satisfied, and in many cases the first, second and third criteria are also not met.

- [10] The 2005 Decision effectively block-exempted this State aid from notification to the Commission, removing any cap on the level of funding that can be granted without notification. Caps are used in other sectors (such as public broadcasting), and apply as a horizontal rule. Beyond specified ceilings, State aid granted for the performance of SGEIs requires notification – except in relation to hospitals and a limited number of other specialised sectors.
- [11] A number of complaints have been brought before the Commission regarding compensation for SGEIs. In respect of hospitals, the implementation of the 2005 Decision has, far from resolving these complaints and bringing legal certainty, if anything exacerbated the problems. The Commission’s current review of the 2005 Decision, and the application of State aid rules to SGEIs, is therefore very welcome.
- [12] State aid funding of public hospitals should not be exempt from notification to the Commission. This perpetuates and entrenches unfair competition between public and private hospitals which distorts the market, reduces incentives to improve efficiency, inflates Member State budgets, and causes harm to consumers and patients. Public funding of hospitals should be assessed under the Community Framework for State aid in the form of public service compensation³ (the “**Framework**”) and the Transparency Directive⁴, like other types of public service funding. Requirements set out by the Framework and the Transparency Directive, which allow the Commission to control and monitor the spending of public budgets, include the requirement that beneficiaries maintain clear and separate accounts of public funding received. This control by the Commission is essential in order to avoid potential distortions of competition including, in particular, overcompensation and cross-subsidisation.
- [13] Reforms must be made to restore a level playing field in the hospital market and avoid continued/further complaints, disputes and market failures across the EU. The number of long-standing complaints from private hospital associations in a number of Member States underlines the fact that this is a long-standing and pan-European problem.
- [14] A detailed impact assessment of the current legal framework applicable to hospital funding (including the 2005 Decision) is both necessary and timely. We respectfully urge the Commission to prioritise the concerns of this sector in its wider review of State aid and SGEIs, and will seek to contribute constructively and support the Commission in any way possible.

3. FACTUAL BACKGROUND

- [15] Throughout almost the entire EU, hospital services are provided in parallel under the framework of two distinct systems: public and private. Public hospital services are typically provided to consumers free of charge at the point of delivery and are financed through public funds, e.g. from State or regional subsidies, or compulsory social insurance. Private hospital services are available in most Member States to all patients either through the public healthcare system, at no direct charge to the patient, or on a fee-paying basis. For example, individuals may choose to join a private insurance

³ Community Framework for State aid in the form of public service compensation, OJ C 397 of 29.11.2005, p.4.

⁴ Commission Directive 2006/111/EC of 16 November 2006 on the transparency of financial relations between Member States and public undertakings as well as on financial transparency within certain undertakings

scheme that gives preferential access to hospitals and treatments as and when they are needed.

- [16] Consumers and patients therefore typically have a choice between public and private hospitals. The availability of this choice creates competition in the hospital sector which, in principle, should improve consumer and patient welfare, and promote efficiency on the part of hospitals. Consumers and patients often choose private hospitals – even when public hospitals are equally available – in order to receive a higher standard of treatment or care, shorter waiting times, and other benefits.
- [17] Additionally, consumers and patients are increasingly able to choose between different hospitals, not only on the basis of their being public or private, but also on the basis of being situated in different regions and even different member States, in order to get the best treatment. The increased mobility of patients within the EU is, we understand, a long-term goal of the Commission, and one element of the overall objective of achieving an internal market for healthcare⁵.
- [18] In parallel, the situation in many Member States is such that public hospitals are unable to meet the needs of consumers and patients in full, due to under-capacity and a lack of resources. Private hospitals provide the additional capacity necessary to ensure fair access to treatment and avoid long waiting lists, and thereby perform a key service on the principle of national solidarity. Private hospitals in many Member States are paid to treat public patients, their payments being drawn from public social security funds according to tariffs set by the government and imposed in the frame of an accreditation agreement. In this respect, they should be considered no different from public hospitals and should receive equal treatment – including with regard to State funding.
- [19] Private hospitals are frequently entrusted by Member State governments with discharging the same SGEIs as the public sector, which is the position enshrined under law in countries including Germany, Belgium, France, and Italy. Whilst this practice has been going on for a long time, the entrustment of SGEIs to private hospitals has increased over recent years and in many Member States all private hospitals are now expected to carry out the same SGEIs as public hospitals.
- [20] For example, in Germany, all licensed hospitals must provide a comprehensive and sufficient treatment and public, private and non-profit hospitals are obliged to provide equivalent services. Similarly, in Belgium, public and private hospitals have the same stated mission, and in France, all establishments involved in psychiatric health care, whether they are public or private establishments, are requested to make their services available to any applicant. The same is also true for private hospitals in Italy, where 93% of private hospitals are accredited to provide SGEIs for the National Health Service to the same extent as public hospitals.
- [21] Private hospitals therefore fulfil a vital role in society by addressing a market failure, filling the gap between the level of service required to ensure universal healthcare, and the level of service that public hospitals are capable of providing. Private hospitals increase the overall capacity of the market by crucially providing extra beds and services. For

⁵ To this end, we understand that a proposal is in place for a directive to improve access to cross-border healthcare. We are also aware that the Commission has recently taken action against Member States that have breached their Treaty obligations by restricting patients' mobility.

example, in Italy 21.9% of the available beds in 2005 were provided by the accredited private sector⁶, while in Belgium this figure is even higher: 66% of beds in 2006 were provided by private hospitals⁷.

- [22] Given that hospitals in the private sector typically accept the same obligations as those in the public sector, they should not suffer overt discrimination with regard to compensation. In all cases, the compensation paid to both public and private hospitals should be linked to the costs of providing the entrusted SGEIs and calculated *ex ante* on the basis of upfront, objective and transparent benchmarks. The compensation received by hospitals should be clearly directed to cover the cost of providing the service which they are obliged by the State to perform.
- [23] However, in practice, public and private hospitals are not compensated on the same basis and do not compete equally when providing the same services. In particular, the State funding for public hospitals in many countries is almost unlimited, with provision for all losses incurred in carrying out the SGEIs – or even non-SGEI activities – covered by national or regional funds. These losses are compensated through so called ‘deficit funding’ or, as in Germany, through guarantor liability schemes. The availability of ‘deficit funding’ and guarantor liability schemes for public hospitals gives them a significant competitive advantage over private hospitals and, in turn, inflates prices in markets adjacent to the hospital sector – including the market for medical equipment, and the market for medical staff.
- [24] Moreover, public hospitals have no incentive to improve the efficiency of their operations because they know that any losses they suffer, no matter how they are incurred or how deep they may be, will be compensated by the State. By subsidising inefficiency in this way, Member States compromise their own budgets and ultimately undermine the efficiency of the EU economy as a whole. This wasteful allocation of public funds has been singled out as a special priority of DG Competition, by Vice-President Almunia⁸. It is also a particular concern in the context of the ongoing financial crisis, as a result of which almost all Member State governments are taking action to reduce their significant deficits, including by cutting public sector budgets. In this context, a system of funding to public hospitals that does nothing to encourage efficiency, and which actively inflates the burden on State budgets by over-spending, surely requires urgent re-examination.
- [25] Furthermore, in many countries, public hospitals receive far greater amounts of State funding than private hospitals carrying out the same services. Not only is this discrepancy inherently unfair, but it also often leads to payments that exceed what is necessary to cover the costs of the SGEIs that the public hospitals perform. According to established principles of EU law, funding should not exceed the costs of the services provided and a reasonable margin of profit. Any excess funding which does go beyond what is necessary is not proportionate. In addition, excess funding received can be used by hospitals for other commercial activities (i.e. cross-subsidisation) and in this way

⁶ Paper prepared by UEHP for their meeting with the Commission, 21 April 2008.

⁷ SPF Santé publique 2005, quoted in the Paper prepared by UEHP for their meeting with the Commission, 21 April 2008.

⁸ See, for instance, Vice-President Almunia’s comments to the CEEP Congress in Madrid on 31 May 2010: “...an efficient allocation of public services, and thus of the public money spent on them, also helps contribute to the competitiveness of the EU, and to economic cohesion between the countries it comprises. Public services must not be seen as just a burden on the public purse: in fact effective and high quality public services actually support and underpin growth and jobs across the EU.”

constitutes incompatible State aid, as defined by the 2005 Decision. This will be discussed in more detail in Section 4 below.

- [26] Above all, the compensation paid to public hospitals in many Member States is obscured by a lack of transparency. It is unclear what the basis for calculating compensation is, and what amounts are paid. This lack of transparency, which is clearly contrary to the spirit and principle of the Transparency Directive, means that it is impossible to verify whether compensation is linked to costs, whether there is any overcompensation paid and, ultimately, what the overcompensation is used for by the public hospitals.
- [27] This unequal treatment of public and private hospitals has a number of adverse consequences. It distorts competition, increases Member State public health budgets, and ultimately harms European consumers and patients. As such, the unequal treatment affects trade in the internal market for healthcare to an extent that is contrary to the interests of the Community. For this reason, UEHP submits that State aid to public hospitals should be notified for assessment by the Commission either *ex ante* or, at least, *ex post*, particularly where the value of such aid exceeds a threshold above which it is likely to cause appreciable distortion of competition.
- [28] The onus must be on the Commission, as the guardian of State aid compliance, to monitor the use of public funds in the most effective way possible. This, UEHP submits, is through *ex ante* assessment. If the Commission develops a system of *ex post* assessment which, for exceptional reasons, is considered more appropriate – as in the case of the 2005 Decision – it must ensure that there are legitimate and justifiable reasons for doing so, and should continuously monitor the system to verify that it remains appropriate in light of changing market conditions.
- [29] UEHP notes, in this respect, that the Commission – and in particular, the Directorate-General for Economic and Financial Affairs – has in the past taken active steps to ensure the proper allocation of resources, the maintenance of proper accounts of public funding, and the overall stability of Member States' economies, for the benefit of the EU as a whole. As part of this exercise, the Commission has been involved in very effective dialogue with Member States for several years, promoting a level playing field, including by direct intervention in some cases. UEHP believes that a similar level of intervention is appropriate in connection with Member States' financing of one of the largest chapters of their budgets, i.e. healthcare. In this context, we respectfully urge the Commission to implement its role as the guardian of State aid compliance with regard to Member States' healthcare budgets and spending.

4. LEGAL FRAMEWORK

Treaty on the Functioning of the European Union and the Altmark Judgment

- [30] Article 107(1) of the Treaty on the Functioning of the European Union (“**TFEU**”) states the general principle that any subsidy or State aid granted by a Member State which distorts or threatens to distort competition by favouring certain undertakings or goods shall, insofar as it affects trade between Member States, be prohibited.
- [31] The application of State aid rules to SGEIs has been specifically addressed by the Court of Justice of the European Union (“**CJEU**”) and the Commission itself.

- [32] In its judgment in the *Altmark* case⁹, the CJEU established that compensation for public services does not constitute State aid under TFEU when four cumulative conditions (the “**Altmark criteria**”) are met:
- First, the recipient undertaking must actually have public service obligations to discharge, and the obligations must be clearly defined;
 - Second, the parameters on the basis of which the compensation is calculated must be established in advance in an objective and transparent manner;
 - Third, the compensation cannot exceed what is necessary to cover all or part of the costs incurred in the discharge of the public service obligations, taking into account the relevant receipts and a reasonable profit; and
 - Finally, where the undertaking which is to discharge public service obligations, in a specific case, is not chosen pursuant to a public procurement procedure which would allow for the selection of the bidder capable of providing those services at the least cost to the community, the level of compensation needed must be determined on the basis of an analysis of the costs which a typical undertaking, well run and adequately equipped, would have incurred.

[33] If Member States do not respect these criteria and if the general criteria for the applicability of Article 107(1) TFEU are met, public service compensation will constitute State aid.

[34] The *Altmark* criteria are not satisfied in the majority of cases of public funding to hospitals; in particular the first, second and third criteria are rarely met, while the fourth is systematically disregarded. As such, EU rules on State aid should apply in full to this funding.

The Altmark Package

[35] Post-*Altmark*, in order to improve legal certainty in respect of the application of State aid rules to public service compensation, the Commission introduced three new pieces of legislation and guidance: the 2005 Decision; the Framework; and the Transparency Directive¹⁰ (together, the “**Altmark Package**”).

[36] The 2005 Decision stipulates when, according to the Commission, Article 106(2) TFEU can be applied to State aid in the form of public service compensation paid to undertakings that are entrusted with performing SGEIs.

[37] Under Article 106(2) TFEU, the application of the normal Treaty competition rules will not apply to undertakings which have been entrusted with SGEIs where the application of the rules would obstruct the performance of the public service tasks assigned to them, provided that trade is not affected to an extent that would be contrary to the interests of the Community.

⁹ *Altmark Trans GmbH and Regierungspräsidium Magdeburg v Nahverkehrsgesellschaft Altmark GmbH* (2003) ECR I-7747
¹⁰ Commission Directive 2006/111/EC of 16 November 2006 on the transparency of financial relations between Member States and public undertakings as well as on financial transparency within certain undertakings.

- [38] Article 106(2) TFEU, as a Treaty exception, should be interpreted narrowly. It is applied by the Commission and hence the Commission requires notification when Member States propose to use it. However, the 2005 Decision specifies conditions under which certain categories of State aid are exempted from this notification requirement. In particular, the 2005 Decision applies to public service compensation of less than EUR 30 million on an annual basis, granted to undertakings with an annual turnover before tax, all activities included, of less than EUR 100 million during the two financial years preceding that in which the service of general economic interest was assigned. The 2005 Decision also specifically applies to public service compensation granted to hospitals carrying out SGEIs, **irrespective of the amount**. Hospitals are therefore exempt altogether from the obligation to notify.
- [39] The 2005 Decision also exempted public service compensation granted to social housing undertakings and certain public service compensation in the field of transport. In UEHP's view, the activities of private hospitals, on the one hand, and social housing providers, on the other, are distinct from each other in terms of financing and their solidarity mission. In this respect, UEHP queries the assimilation of the two, and questions whether it is necessarily appropriate for the same State aid block exemption to apply to both.
- [40] All other public service compensation, which does not satisfy either the *Altmark* criteria or the conditions of the 2005 Decision for exemption, must be notified to the Commission, who will assess its compatibility with the common market in line with the Framework.

Application of the Altmark Package

- [41] As outlined above, the 2005 Decision allows certain public service compensation to be exempt from notification in specific circumstances. This includes compensation paid to hospitals carrying out SGEIs. The practical application of those provisions of the 2005 Decision has led to significant problems in the healthcare sector across Europe.
- [42] On the basis of the exemption in the 2005 Decision, Member States have been funding public hospitals without notifying the Commission, using State aid which:
- Overcompensates public hospitals for the SGEIs with which they are entrusted;
 - Allows public hospitals to cross-subsidise, i.e. to use their SGEI compensation to fund non-SGEI activities (as in the case of German hospitals cross-subsidising walk-in healthcare clinics which compete with private physician's practices);
 - Discriminates between private and public hospitals; and
 - Distorts competition in the hospital market and adjacent markets, ultimately causing harm to consumers and patients.
- [43] These repeated, systematic, pan-European failings in the application of the 2005 Decision are significant enough to affect trade to an extent that is contrary to the interests of the Community. The conditions of Article 106(2) TFEU are therefore not satisfied and the compensation cannot be exempted from the normal State aid rules.
- [44] The 2005 Decision itself outlines a number of checks and procedures to ensure that the exemption is applied correctly. These include reporting obligations, rules regarding

overcompensation, and transparency obligations. However, the 2005 Decision has not been satisfactorily implemented with regard to hospitals¹¹. As set out above, overcompensation is being paid routinely and it is not clear whether this is being accounted for or recovered. It is also not clear whether the Commission has received any information from the Member States regarding the implementation of the 2005 Decision (and in particular the *ex ante* calculation of costs), whether separate accounts are being kept by hospitals receiving compensation, the amount of compensation being paid, or whether procedures are in place for overcompensation to be recovered. These questions will be assessed in more detail in Section 7 below.

Failings of the Altmark Package

- [45] UEHP believes that not only has the 2005 Decision been implemented wrongly in practice, but also that it is wrong in principle.
- [46] UEHP urges the Commission to remove the existing exemption from notification that applies to compensation to hospitals, so that the Commission can assess the compatibility of this State aid with the common market on the basis of the Treaty and the Framework, as it does with other public service compensation.
- [47] The Commission based the exemption in the 2005 Decision on its assessment of the internal market for healthcare, as described in paragraph 16 thereof:

*Hospitals [...] which are entrusted with tasks involving services of general economic interest have specific characteristics that need to be taken into consideration. In particular, account should be taken of the fact that at the current stage of development of the internal market, the intensity of distortion of competition in [this sector] is not necessarily proportionate to the level of turnover and compensation. Accordingly, hospitals providing medical care, including, where applicable, emergency services and ancillary services directly related to the main activities, notably in the field of research [...] should benefit from the exemption from notification provided for in this Decision, even if the amount of compensation they receive exceeds the thresholds laid down in this Decision, if the services performed are qualified as services of general economic interest by the Member States.*¹²

On this basis, it was decided that the hospital sector should benefit from the exemption from notification **irrespective of the amount of compensation granted**. This is in direct contrast to almost all other sectors.

- [48] UEHP disputes that this was an accurate reflection of the internal market for hospital services in 2005. We would appreciate the opportunity to discuss with the Commission the economic assessment on which it based this conclusion.

¹¹ On the importance of full implementation of the rules set out in the 2005 Decision, please see comments made by Adina Sinnaeve, member of the Commission staff in DG Competition Unit A.3, State aids Policy and Scrutiny, at the 8th Experts' Forum on New Developments in European State Aid Law on 10 June 2010: "The poor application of the rules is a genuine problem to be addressed".

¹² 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, OJ L 312, 29.11.2005, p.69 at paragraph (16).

- [49] In any event, notwithstanding that this assessment was inaccurate in 2005, it is certainly inaccurate, to an even greater extent, in 2010. The internal market for hospital services has developed considerably in the last five years. Firstly, the significant contribution made by the private hospital sector to providing universal healthcare has grown, as discussed in the introduction to this paper. Secondly, patient mobility between regions and/or Member States has increased dramatically, supported and endorsed by the Commission, for example in its proposal for a Directive on the application of patients' rights in cross-border healthcare. In parallel, the Commission has recently taken specific action against three Member States (Spain, Slovakia and Denmark) for breaching their Treaty obligations by restricting patients' access to cross-border healthcare. Finally, the structure of ownership in the internal market for healthcare has changed, with more hospitals now being owned cross-border by non-nationals (for example, the Swedish ownership of several private hospitals in France).
- [50] UEHP respectfully submits that, were the Commission to repeat today the economic assessment (if any) it carried out in 2005, it would find no justification for exempting the hospital sector from the general notification requirements in the 2005 Decision. The exemption should therefore be removed. The cumulative effect of the repeated, systematic and widespread grant of unnotified State aid to public hospitals, including overcompensation for the services they provide and uncapped commitments to reimburse their deficits, is undoubtedly to affect trade and distort competition.
- [51] If the Commission believes that the existing exemption under the 2005 Decision must remain in place, we believe that it should at least be capped. In recognition that the internal market for healthcare has "specific characteristics", State aid below a certain level could be exempted from notification, provided, again, that the conditions in the 2005 Decision are met. However, all State aid granted above this level would have to be notified and assessed by the Commission under the Treaty and the Framework.
- [52] The cap could be set, for example, above the *de minimis* threshold provided for in Article 2(1)(a) of the 2005 Decision, but at a level which would prevent the possibility of overcompensation or excessive deficit funding. This concept is developed in more detail in Section 7, below.
- [53] The Commission has recently produced a Communication on Public Sector Broadcasting (the "**Communication**")¹³. The broadcasting sector is one where the Commission faced challenges applying the State aid rules and the Framework, given the specificities of that industry. There were numerous complaints from the private sector that the public sector was receiving unfair advantages. In order to solve these problems, the Commission introduced certain guidelines in the form of the Communication. The Communication applies the theory of the 2005 Decision in practice, and lays down a number of principles which demonstrate that the Framework and Transparency Directive can be successfully applied to compensation to specific sectors of public services, including sectors typically regarded as especially sensitive. In particular, the Communication sets out transparency obligations, for example the requirement of separate accounts, principles dealing with overcompensation, and Member States' and the Commission's ability to review the proportionality of compensation. We think that these guidelines are equally useful for the

¹³ Communication from the Commission on the application of State aid rules to public service broadcasting, OJ C 257 of 27.10.2009, p.1-12.

hospital sector, and later in this paper we discuss which rules in particular are suitable to apply to hospitals in order to resolve the current problems with the application of the *Altmark* Package.

5. PREVIOUS SUBMISSIONS TO THE EUROPEAN COMMISSION

[54] There has been a long history of disputes and complaints brought by members of the private health sector regarding State funding of public hospitals. The problems arising and the distortion to the market are pan-European problems, as evidenced by the fact that private hospital associations in a number of Member States have all raised similar complaints.

[55] The complaints by the associations in each of the Member States have been based largely on the following key arguments:

- There is a lack of transparency in the funding of public hospitals, such that the public compensation provided does not satisfy the *Altmark* criteria;
- The services conferred on public hospitals by the State are insufficiently defined, again in breach of the *Altmark* criteria;
- State funding for public hospitals should not exceed the level of compensation required for the SGEIs conferred, i.e. there should be no overcompensation or cross-subsidisation; and
- Hospitals should not receive unlimited public funding to cover losses or deficits incurred in their discharge of the SGEIs conferred upon them.

[56] For the Commission's reference, and to illustrate the history of unresolved issues that the current system of hospital funding has created, we have set out below a brief overview of complaints brought by private hospital associations at national level¹⁴. For the avoidance of doubt, please note that in the following paragraphs UEHP has summarised the arguments put forward in a long series of complaints to the Commission by other organisations. The arguments expressed do not necessarily reflect the views of UEHP, and UEHP has not been sanctioned by these organisations to make representations to the Commission on their behalf in respect of these specific complaints.

December 2000 and August 2003, France – Complaint by FHP

[57] On 8 December 2000, FHP lodged a complaint before the Commission, which it then restated in August 2003. UEHP understands that the Commission did not open a full investigation on the basis of these complaints. The FHP argued that compensation provided to hospitals under a scheme passed in 2000 was incompatible with the common market and therefore that any aid granted under the scheme should be repaid. In support, FHP put forward the following arguments.

¹⁴ Please note that in Section 5 we consider complaints that were lodged with the Commission prior to the meeting with UEHP in April 2008. Later complaints, and other evidence of ongoing pan-European failure, are set out in Section 6.

Hospitals are not treated equally

- [58] In 2000, the French government committed to pay public, private and non-profit hospitals supplementary assistance amounting to EUR 1.52 billion over 3 years. The FHP complaint set out that, in practice, public and non-profit hospitals received government support for activities identical to those carried out by private hospitals, for which private hospitals received no funding. The system therefore had the effect of distorting competition between the public and private sectors.

The Altmark criteria are not satisfied

- [59] Furthermore, the complaint set out that the public/non-profit hospitals concerned had never been properly entrusted to discharge SGEIs and the *Altmark* criteria were therefore not satisfied.

The funding is incompatible with Article 107 TFEU

- [60] FHP argued that as the funding scheme had never been notified to the Commission, it constituted unlawful State aid. Any payments which had been made pursuant to this scheme should therefore be repaid.

March 2004, Italy – Complaint by AIOP

- [61] In March 2004, the Italian Association of Private Hospitals (Associazione Italiana di Ospedalita Privata, “**AIOP**”) lodged a complaint before the Commission. UEHP understands that the Commission initiated a State aid investigation on the basis of this complaint, which is currently dormant. AIOP presented three main arguments in its complaint: breach of Article 101 TFEU, (ii) breach of Article 102 TFEU, and in particular, (iii) unlawful State aid. In support, AIOP put forward the following arguments.

Hospitals are not treated equally

- [62] The National Health Service in Italy unfairly privileges public hospitals in the allocation of resources and remuneration for SGEIs, with respect to other undertakings present on the market. Private hospitals performing services for the State suffer inherently discriminatory treatment.

The Altmark criteria are not satisfied

- [63] AIOP argued that the compensation paid to hospitals by the Italian State and regions does not satisfy any of the *Altmark* criteria. AIOP identified an anomaly in the participation of the public local health agencies (“**ASLs**”) in determining the nature, quantity and price of services to be performed by hospitals, which they negotiate on behalf of the National Health Service. This is because hospital services are entrusted either to institutions run by the ASLs themselves, or to private establishments with the National Health Service’s accreditation. The ASLs, in their dual role as both procurer and provider of services, finance their own establishments first, and then allocate to the private sector those services that remain. Moreover, the ASLs frequently attribute an entirely different value to services, depending on whether they are entrusted to their own (public) hospitals, or to private hospitals.

- [64] In this respect, the ASL's control over the public health budget becomes a tool by which to squeeze the operating margins of private hospitals, while it is difficult to reconcile the budgets allocated to public hospitals with the services that they perform. Moreover, it leads to a clear breach of the ASL's obligation to ensure it receives best value for public money. No regard is given to the (very often) greater levels of efficiency offered by private hospitals, compared to hospitals operated by the ASL itself. At the same time, there is a fundamental lack of equal treatment as the ASLs have indicated a general reduction in the prices to be paid for hospital services, while at the same time providing to their own hospitals additional payments that are not transparent, and in no way reflect the value of the services provided.
- [65] It should be noted that the ASLs are defined within the Italian healthcare framework as "enterprises having public legal personality, with autonomous rights of management", whose organisation and functioning are determined according to private company law. The activity of the ASLs is economic in nature, as they participate in the market for the procurement and provision of healthcare services, in competition with other firms. These firms include private healthcare providers which are members of AIOP.
- [66] The mission conferred upon public hospitals is not clearly defined. Furthermore, the compensation that public hospitals receive is not clear or transparent. Finally, as said above, the beneficiaries of the payments made under this system are not efficient.

Overcompensation is paid

- [67] The compensation that many public hospitals receive exceeds the cost to these hospitals of discharging the mission conferred upon them, plus a reasonable margin. Furthermore, public hospitals receive additional compensation in the form of direct financing to buy expensive technical equipment, which is not available to private hospitals.

Other arguments

- [68] AIOP argued that in addition to the unlawful State aid outlined above, there had also been a breach of Article 102 TFEU.
- [69] With regard to Article 102 TFEU, the ASLs enjoy a legal monopoly in the acquisition of health services on behalf of the State, as they are granted exclusive rights under Article 106 TFEU. The complaint argued that the State had induced an abuse of the dominance that the ASLs exercise, by way of predatory pricing.

January 2003 and December 2007, Germany – Asklepios Kliniken joined by BDPK

- [70] In January 2003, Asklepios Kliniken GmbH lodged a complaint before the Commission¹⁵. This was followed, in August 2003, by the submission of a legal opinion on the *Altmark* criteria. Subsequently, in December 2007, Bundesverband deutscher Privatkliniken

¹⁵ Asklepios Kliniken GmbH brought an action before the Court of First Instance in May 2004 citing the Commission's failure to act following its complaint. Although the Court dismissed this action, it upheld the applicant's *locus standi*, and also confirmed (at paragraph 88) that "*preparation of a general decision on State aid in the form of public service compensation granted to certain undertakings entrusted with the operation of services of general economic interest cannot release the Commission from its obligation to conduct an individual examination of the applicant's complaint*". The Court thereby established that the Commission is obliged to examine the merits of all complaints regarding unlawful aid for the performance of SGEIs, notwithstanding the position adopted in the 2005 Decision.

(“BDPK”), the governing body for private hospitals in Germany, joined the complaint which is still ongoing before the Commission (see paragraph [105] *et seq.* below. The joint complaint put forward the following arguments.

Hospitals are not treated equally

- [71] Both public and private hospitals obtain financial support on the basis of the Hospital Financing Act¹⁶ and hospital supply contracts. However, subsidies paid per bed were higher for public hospitals than for private hospitals. For example, in 1998-2001, subsidies were about EUR 8,800 per bed each year for public hospitals and only EUR 6,500 per bed each year for private hospitals. In addition, public hospitals are assured that their losses will be covered by public authorities and guarantees, which are potentially unlimited. This system confers a significant advantage on public hospitals, particularly in terms of recruiting staff and acquiring new equipment. These factors are of primary concern to patients and a key consideration in choosing a hospital. The advantage conferred on public hospitals therefore directly affects competition for patients.

The Altmark criteria are not satisfied

- [72] Asklepios Kliniken argues that the Hospital Financing Act did not satisfy the first *Altmark* criterion as the public service obligations entrusted by the legislation are not clearly defined. Public service obligations are not exclusive to public hospitals, and private hospitals have equal obligations.
- [73] In addition, it was alleged that the public authorities’ decision-making was not consistent or transparent, and there are no objective and transparent qualification or calculation criteria for the compensation granted. Therefore, the second of the *Altmark* criteria is not satisfied.
- [74] In contravention of the third criterion, the hospitals receive overcompensation (see below) and the level of compensation received is not calculated on the basis of a counterfactual efficient undertaking, as it should be under the *Altmark* criteria. As a consequence, the public hospitals therefore have no incentive to operate efficiently and reduce their costs.

Overcompensation is paid

- [75] Asklepios Kliniken also argued that public hospitals are overcompensated. Public hospitals do not fulfil any additional obligations of general economic interest beyond those also discharged by private hospitals, and therefore no additional compensation should be paid to them. The additional compensation paid results directly in overcompensation of the public hospitals. In particular, the guarantor liability scheme potentially covers the public hospitals’ losses to an unlimited extent. The scheme therefore constitutes unlawful State aid, as unlimited guarantees are *per se* incompatible with Article 107 TFEU.
- [76] Asklepios Kliniken suggested that the Commission should assess potential overcompensation by measuring State funding against each beneficiary’s actual costs, rather than a hypothetical ‘as efficient competitor’.

¹⁶ Krankenhausfinanzierungsgesetz – The Hospital Financing Act of 1972 (KHG).

August 2005 and January 2007, Austria – VPO

- [77] Verband der Privatkrankenanstalten Osterreichs (“**VPO**”) submitted two letters to the Commission, in August 2005 and in January 2007, but did not receive any response from the Commission. The letters put forward the following arguments.

Hospitals are not treated equally

- [78] Financing of hospitals in Austria varies between the federal states, and there are three main operators of hospitals: confessional non-profit private hospitals, hospitals operated by authorities (federal states, communities etc.), and for-profit private hospitals.
- [79] The confessional hospitals and hospitals operated by authorities receive basic payments from the federal state sanitary funds (“**Landesgesundheitsfonds**”). The for-profit private hospitals receive basic payments from a fund founded especially for this purpose (the “**PRIKRAF**”). The Landesgesundheitsfonds and the PRIKRAF both receive their budget mostly from public social insurance funds.
- [80] The confessional hospitals and the for-profit hospitals, however, have no (or limited) legal entitlement to receive additional payments from the federal states to cover their losses. Rather, they depend on voluntary payments (“**Subventionen**”) from the federal states. By contrast, hospitals operated by the authorities enjoy a right under law to have their losses covered. Moreover, the voluntary payments of Subventionen – if given – are not allocated objectively according to different hospitals’ needs.
- [81] The 2005 letter proposed that an amendment should be made to the Commission’s (then draft) 2005 Decision to the effect that all operators are to be treated equally, irrespective of whether they are run directly or indirectly by authorities. Any State aid which amounts to unequal treatment should be declared incompatible. Furthermore, the 2007 letter added that payments made by fund providers should be subject to cost efficiency criteria, i.e. performance-related financing. Without these measures, the confessional, non-profit private hospitals would not be able to survive, resulting in further strain on the healthcare system.

October 2005, Belgium – CBI and ABISP

- [82] In April 2005, two hospital associations in Brussels lodged a complaint before the Commission. The Commission issued a decision in this case in October 2009 – see paragraph [95] below. The complaint originally submitted by the Belgian associations made the following arguments.

Hospitals are not treated equally

- [83] The complaint set out that public hospitals should not receive public compensation for losses incurred in the discharge of their SGEIs. The criteria for such compensation are vague and there are no effective controls over this overcompensation. Private and public hospitals are entrusted with the same SGEIs and there therefore should be no discrimination between them.

The Altmark criteria are not satisfied

- [84] The associations' complaint alleged that, in breach of the *Altmark* criteria, the SGEIs conferred by the State on public hospitals are insufficiently and unclearly defined. Furthermore, the compensation received by public hospitals for their discharge of SGEIs is insufficiently transparent.

Overcompensation is paid

- [85] The complaint also argued that the Regional Funds of Refinancing of the Communal Treasuries of Brussels ("**FRBRTC**") overcompensates public services, including public hospitals, without transparent rules or limits.

June 2008 and November 2009, France – UNCPSY

- [86] On 30 June 2008, UNCPSY brought a complaint against France for breach of the State aid rules. Following this and a meeting between UNCPSY and the Commission in October 2009, UNCPSY submitted an additional paper in November 2009. UEHP understands that this case is ongoing before the Commission. In its complaint and the follow-up paper, UNCPSY made the following arguments.

Hospitals are not treated equally

- [87] UNCPSY claimed that public hospitals are overcompensated for performing their public service obligations. In addition, the State confers benefits on public hospitals to the exclusion of private hospitals. The French government grants preferential financial conditions to public hospitals, such as long term loans with zero or minimal interest, and exemptions from the payment of certain taxes. The French government also grants various advantages to the employees of public hospitals, for example, favourable salaries, pensions, accommodation and holidays. These advantages constitute State aid that therefore favours public hospitals to the detriment of competing private clinics.
- [88] The French government also imposes price restrictions on private psychiatric clinics, which prevent them increasing their prices and therefore prevent them from offering their services at a price that would adequately cover their costs. Furthermore, restrictions prevent private psychiatric clinics from increasing their number of beds. These restrictions also limit the clinics' ability to compete with the public sector.

The Altmark criteria are not satisfied

- [89] UNCPSY claimed that public service obligations are almost systematically trusted to public hospitals without any tender. According to UNCPSY, compensations are fixed without any control and are not capped. The *Altmark* criteria are therefore not satisfied.

Overcompensation is paid

- [90] UNCPSY went on to argue that public hospitals in France are overcompensated for their public service obligations, and in parallel, the State systematically covers their losses.
- [91] In addition, there are no clear, transparent and separate accounting procedures in place within public hospitals to sufficiently identify which costs and revenues are attributable to

public service obligations, and which relate to commercial economic activities that should be subject to competition in the market. Public funding is therefore disbursed with no possible control, no adequate justification for the amounts granted, and no check on their final use.

Request for interim measures

[92] UNCPSY asked for interim measures, including:

- To order the relevant French authorities to allow private psychiatric hospitals to provide services at prices equivalent to those charged by public hospitals when carrying out SGEIs;
- To order the relevant French authorities not to impose on private psychiatric hospitals an obligation to charge below their costs; and
- To order the relevant French authorities to notify any new aid that would not qualify for an exemption.

[93] Finally, UNCSPY explained that the internal market for healthcare has developed since 2005 and that there has been a significant body of Community case law, as well as Commission guidance and information on the correct application of the State aid rules. The derogation from the Treaty in favour of existing aids to hospitals has therefore, in some cases, lost its *raison d'être*.

6. EVIDENCE OF CURRENT PAN-EUROPEAN FAILURE

[94] In addition to the complaints set out in Section 5 above, which relate to actions commenced prior to UEHP's meeting with the Commission in 2008, we can also provide further evidence of the distortion of competition arising from the current framework of State funding to hospitals. The examples below relate to developments that have taken place subsequent to UEHP's meeting with the Commission.

October 2009, Belgium – NN 54/2009

[95] In October 2009, the Commission issued its decision in the case concerning the funding of hospitals in Brussels (see paragraphs [82]– [85] above for a summary of the complaint submitted).

[96] The Commission found that funding granted following the adoption of the 2005 Decision was exempt from notification, but that any funding granted before then that had not been notified for assessment constituted illegal aid. Despite going on to conclude that the aid in question was compatible with the common market, the following points were made clear by the Commission's assessment of the Belgian measures¹⁷:

- Compensation paid to public hospitals will in principle distort competition, and must be assessed on this basis;

¹⁷ For the avoidance of doubt, in summarising the Commission's decision, UEHP makes no submissions as to its merits. Any views expressed by UEHP in respect of the decision are without prejudice to the views of the parties themselves.

- A compensation regime based on a simple average of the costs incurred by several hospitals performing SGEIs cannot ensure that no overcompensation is paid to each, as it will not take into account the real net costs of individual undertakings;
- In principle, the criteria for the compensation of public hospitals' deficits should be established in advance, and the specific criteria that hospitals have to fulfil to be eligible to receive compensation should be transparent. Procedures for verification should also be in place; and
- To ensure that these transparency obligations are respected, the undertakings receiving compensation should maintain separate accounts and clearly allocate the costs and revenue attributed to the performance of the SGEIs with which they were entrusted. The undertakings should also provide relevant national authorities with suitable accounting information, and maintain a record of the funding received.

[97] As such, in this case, the Commission found that compensation granted to the particular public hospitals in question was compatible with the common market because adequate safeguards (against, in particular, overcompensation) were in place. Nevertheless, the Commission did acknowledge the potentially serious distortion of competition that State funding of hospitals can cause. Moreover, by emphasising the importance of structural and accounting safeguards, verification and transparency, the Commission endorsed many of the very principles that UEHP seeks to propose in this paper.

2010, Italy

[98] For many years, public hospitals in Italy have benefited from automatic coverage of their deficit at the end of each year. In particular, in a number of regions, this has become the normal practice, and it has driven the deficit of the health system in these regions to incredibly high levels.

[99] This problem is particularly severe in regions including Lazio, Campania, Abruzzo, and Calabria. These regions are subject to stringent economic/financial programmes by the national Government, and are monitored by an external commission, with a view to addressing their deficits.

[100] In this respect, it should be noted that the sizable healthcare deficits that some regions have incurred cannot be attributed to the private hospital sector, whose services are paid for on the basis of the DRG. By contrast, public hospitals benefit from having both their costs and their deficits paid in full, with the amount of each subject to no scrutiny whatsoever. On this point, the Minister of the Treasury has recently expressed the view that the accounts of public hospitals are not entirely transparent.

[101] One region in which the level of the public health system's debt has reached unsustainable levels is Campania, where the debt for the period 2001-2008 is in the region of EUR 7 billion, and EUR 949 million in 2009 alone. Together with Lazio, which has a deficit of EUR 9 billion, Campania accounts for more than half of the total debt of the Italian public health sector.

- [102] In Calabria, meanwhile, the deficit of public hospitals amounted to approximately EUR 476 million in 2007, and EUR 1,125 million in 2008 and 2009. As indicated by widespread press articles, the public debt related to the health system in Calabria may now amount to over EUR 2 billion. Moreover, if one compares the cost-efficiency of private and public hospitals in Calabria, the average cost of medical services in a public hospital in Calabria is approximately 200-300% higher.
- [103] In addition, public hospitals in Calabria operate at incredibly high capacity. Statistics of beds per employee reveal many examples in which the ratio is more than 2 or 3 healthcare workers per patient, with some peak cases of as many as 7 or 8 healthcare workers per patient.
- [104] Recent press articles¹⁸ reported that the national government is going to impose a policy whereby the regions in which health system deficits are higher will have to impose taxes on their citizens to cover those deficits. In other words, even more public money will be spent to cover the health system deficits that are created by public hospitals' inherent and systemic inefficiencies. Clearly, a system whereby public hospitals know that at the end of the year their deficit will be covered by the national and/or regional governments' budget cannot but lead to a series of inefficiencies and higher costs to the detriment of the final consumer, i.e. the patient. In effect, there are a number of negative consequences. Taxpayers in the regions above pay higher rates and charges than those elsewhere, and patients receive lower quality services – as is demonstrated by the rate of patient mobility away from these regions.

December 2009, Germany – Opinion of BDPK concerning the report of the Federal Republic of Germany about the 'Altmark Package' of the European Commission

- [105] In December 2009, BDPK presented to the Commission an opinion on the German government's report on the Altmark Package. This opinion was prepared by BDPK after the 2005 Decision had entered into force and been applied in Germany, and outlines the shortcomings of the implementation of the 2005 Decision. The main arguments put forward by the BDPK are outlined below.
- [106] Primarily, the BDPK does not think that it is necessary to have a special exemption from State aid notification in the hospital sector. The provisions of the EU Treaty, together with the *Altmark* criteria laid down by the CJEU, are universal in scope. With regard to State aid, the internal market for healthcare does not differ from any other economic sector and therefore does not merit a special exemption. Indeed, BDPK argues, it is unlawful to use the exemption in Article 106 TFEU as a general principle in the internal market for healthcare.
- [107] In the alternative, BDPK proposes that if the Commission will not remove the exemption under the 2005 Decision altogether, it should revise the applicable criteria.

¹⁸ See e.g. Corriere della Sera 13 May and 28 June 2010, La Repubblica 1 and 2 July 2010.

Flaws in the Federal Republic report

- [108] The BDPK reviewed the report prepared by the Federal Republic of Germany on the implementation of the 2005 Decision, and noted in particular that:
- The report did not comply with the requirements laid down in Article 8 of the 2005 Decision, namely the **duty of the Member State to report to the Commission**;
 - Under Article 8, the report should describe whether and how the requirements for the **act of entrustment** (Article 4) are met in practice. If the Federal Government is not able to provide this information in every single case due to the large number of acts of entrustment, it must at least describe how compliance with the provisions of Article 4 is ensured, i.e. through institutions responsible for implementation and supervision or through an organisational structure of implementation and supervision. For example, this could be achieved by establishing a **national entrustment register**, or by appointing a person responsible in each federal state for the implementation of Article 4. However, the report prepared by the Federal Government does not include any information about such measures;
 - Article 6 of the 2005 Decision requires effective controls of overcompensation. The BDPK is of the view that the measures of control described in the Federal Government's report are **not sufficient to provide the necessary transparency**, in particular because the relevant audits are not carried out by an independent organisation, the relevant legal basis for the audits is not explicitly identified, and the Federal Government does not adequately review the audits performed; and
 - The report also fails to provide a sufficient level of transparency with regard to deficit compensation, and even states explicitly that there is **no reliable information** about the amount of deficit compensation that has been provided to public hospitals.

BDPK's proposals for change

- [109] BDPK concluded by putting forward a number of suggestions to improve the application of the criteria set by the 2005 Decision which must be satisfied for compensation to hospitals to be exempt from notification:
- The definition of SGEIs must be improved. The SGEI should only constitute a special duty within the meaning of Article 106(2) TFEU if (i) it cannot be carried out without deficit compensation and such compensation is not already covered by other means (such as regular hospital funding) and, (ii) other market participants are also unable to provide such services without deficit compensation;

- The compensation permitted to be granted without notification under the 2005 Decision must be not only necessary, but adequate. Compensation should be limited to an amount that an economically efficient third party would require; and
- To improve transparency, a European register that lists all public compensation paid should be established and should be made available for public inspection. This register would enable competitors of a hospital which has received compensation, who suspect that this may constitute unlawful State aid, to substantiate their case prior to initiating preliminary proceedings before the Commission.

[110] We understand that this case is currently ongoing, and that the parties held a meeting earlier this year with the Commission, which indicated that it would consider assisting in the development of measures to increase *ex ante* transparency in funding.

France – continued structural failings in hospital funding

[111] UEHP is also aware that there are significant failings in the current structure (including the relevant legislative framework) for the funding of hospitals in France. Substantial over-compensation of public hospitals, triggering distortions of competition in the national market for healthcare, is demonstrated by a series of factors.

Tariffs allocated to public hospitals are higher than those allocated to private hospitals for the same treatments

[112] The French system of hospital funding is based upon a series of tariffs, under which funds are allocated to hospitals according to both their status and the treatments that they offer. The relevant tariff rates are reviewed annually, and are made public via publication in the Official Journal.

[113] A simple review of the tariffs in recent years indicates that hospitals in the public sector receive on average 50% higher funding than private hospitals for performing equivalent services. The relevant French legislation aims for convergence between the tariffs allocated to the public and private sector, but has set a goal of achieving convergence only in 2018 – meaning that distortions of competition will continue at least until then. Moreover, the target of 2018 is later than was originally intended; the legislation had set a goal of 2012 to achieve full parity between the public and private sectors, but this deadline was pushed back in 2010.

[114] Several independent studies have looked into this issue in recent years, and all have found that the discrepancy in funding remains wide, and progress towards convergence remains slow:

- A report by the *Inspection Générale des Affaires Sociales*, based on statistics from 2005, showed that the average cost of health insurance in the public sector was 81% higher than in the private sector for an equivalent stay in hospital;
- A further study by the *Caisse Nationale d'Assurance Maladie des Travailleurs Salariés*, based on 2006 figures, reported an average 60% difference between tariffs allocated to the public and private sectors;

- The French Ministry for Health's October 2009 report on convergence in hospital tariffs reported that tariffs to the public sector should be reduced by 37% to achieve convergence with tariffs in the private sector; and
- The Ministry's subsequent October 2009 report stated that a 27% reduction in public sector tariffs was required to achieve convergence.

The public sector benefits from additional, discretionary funding for SGEIs

- [115] The French hospital funding system is also inherently discriminatory insofar as it affords Regional Health Authorities absolute discretion to allocate funds for the performance of SGEIs. Funding is not allocated uniformly to all hospitals to compensate them for their SGEI functions. Rather, the Regional Health Authorities entrust hospitals with SGEIs and, separately, allocate funding to the hospitals that perform them. This typically results in public sector hospitals receiving far higher compensation than private equivalents.
- [116] In addition, there is a fundamental imbalance in the allocation of funding to public and private hospitals in France's budget for SGEIs. In 2008, private hospitals received less than 1% of the total SGEI budget, which represented 0.007% of their total income in the year. In the public sector, by contrast, receipts from the SGEI budget represented around 20% of total income. In total, private hospitals received EUR 41.6 million in 2008 in compensation for their performance of SGEIs, out of a total national budget of EUR 4.27 billion. Private hospitals are excluded altogether from funding for certain types of SGEI, such as medical research, even though they do perform such services.
- [117] Finally, there is clear discrimination in the allocation of funds to cover French hospitals' deficits. In 2008, State aid to finance deficits ("*Aides à la Contractualisation*") totalled EUR 2.32 billion in 2008, of which private hospitals received only EUR 23.2 million.

Public hospitals benefit from substantially greater investment than private hospitals

- [118] In 2003, France put in place a five-year plan for investment in hospitals (2003-2007); this was followed by a second five-year plan, from 2008-2012. Under the current plan, "*Hôpital 2012*", 85% of all investment aid has been allocated to hospitals on public tariffs – despite these only accounting for two-thirds of all hospital activity in France.
- [119] A study published in August 2009 by the *Agence Nationale d'Appui à la Performance* found that private hospitals will receive EUR 411 million of direct State funding towards investment, with a target of generating total investment of EUR 2 billion. By contrast, public sector hospitals will receive EUR 5.3 billion of aid with a target of generating a total EUR 15 billion in investment. Not only do public sector hospitals receive far greater levels of direct State funding, but also this State funding represents a larger proportion of the total overall investment they will receive: 37% for the public sector, compared to around 20% for the private sector.
- [120] Moreover, investment in the private sector under *Hôpital 2012* will be limited to capital investment – private sector hospitals will not receive any aid towards their operating costs. Public sector hospitals, however, will receive substantial operating aid. Ultimately, as well as distorting the internal market for healthcare in France, this will inflate the national healthcare budget and increase the already high levels of debt in public hospitals.

Discriminatory fiscal treatment

- [121] In addition to all of the above, which clearly shows that there is a systemic imbalance in the funding of public and private hospitals in France, one additional factor must also be taken into account. As well as receiving less funding from the State than public hospitals, under the tariff system, under the budget for SGEIs, and in investment, private hospitals also suffer higher fiscal and social charges.
- [122] The difference in tax treatment for the public and private sector creates a differential burden of around 5% on hospitals themselves. Moreover, workers in private hospitals are left between 6% and 9% worse off, in terms of net salary, than their counterparts in the public sector.
- [123] This higher fiscal burden, when combined with the lower levels of State support, clearly illustrates that, in France, there is significant, quantifiable and unjustifiable discrimination against private hospitals.

Bulgaria – ongoing discrimination against private hospitals

- [124] In Bulgaria, the private sector in 2009 accounted for 30.4% of all hospitals, caring for some 18% of patients admitted for treatment. Private hospitals perform SGEIs alongside public hospitals, and make a significant contribution towards the national healthcare system by alleviating under-capacity and a lack of resources.
- [125] Nevertheless, these private hospitals are subject to direct discrimination in terms of compensation. Public hospitals, which perform the same services, receive targeted subsidies from State and municipal budgets for the acquisition of fixed assets, renovation/overhauls, and installation and upgrade of IT systems, as well as financial aid. In addition to granting public hospitals an unfair advantage over private competitors, this system also inflates prices for medical equipment and other inputs in the hospital sector. Moreover, the payments to public hospitals reduce their incentives to improve efficiency, inflating the national healthcare budget, and ultimately harming patients.

October 2010, France – FHP-MCO

- [126] In October 2010, the Fédération Hospitalière Privée – Médecine, Chirurgie et Obstétrique (“**FHP-MCO**”), a professional syndicate representing around 700 private facilities providing hospital care (including in-patient treatment) for Medicine, Surgery and Obstetrics (“**MSO**”) in France, lodged a complaint with the Commission. FHP-MCO represents 100% of the private, for-profit MSO medical care facilities in France, and is itself affiliated with FHP.
- [127] In its complaint to the Commission, FHP-MCO submits that public funding is unequally allocated between the public and private sectors: in 2008, EUR 55.2 billion was provided to public hospitals compared to only EUR 11.5 billion to private hospitals. In addition, FHP-MCO points out that public hospitals receive a global allocation of funding, in contrast with private hospitals which are funded according to tariffs set per day of care with fixed prices for accessory services. In the same vein, private hospitals can charge only for a limited number of healthcare services (which reduces the resources available to them) while, at the same time, they are deprived of the more generous funding granted to public hospitals.

- [128] Despite the reforms aimed at the convergence of tariffs (see paragraphs [111] to [123] above), a system of inherent discrimination with no valid justification remains. FHP-MCO had previously referred a case to the French *Conseil d'Etat* in this respect, but the *Conseil* confirmed the jurisdiction of the Commission to decide on the compatibility of State aid granted by the French authorities.
- [129] It is against this background that FHP-MCO lodged its complaint before the Commission. FHP-MCO relies on a series of studies that all fail to identify any objective reasons to justify the discrepancies in the funding of public and private hospitals. According to FHP-MCO, the system in place benefits public hospitals to the detriment of private equivalents. The choice available to consumers and patients is reduced as a result of the limitations imposed on the services that the private sector can provide.
- [130] The financial support to public hospitals clearly falls within the definition of State aid and, therefore, is *prima facie* incompatible with the TFEU. Likewise, the funding fails to satisfy the *Altmark* criteria or even the requirements of the 2005 Decision, since funding is provided to public hospitals which is in no way calculated to reflect the costs of the SGEIs they perform, and which includes unlimited deficit funding.

7. PROPOSALS FOR CHANGE

- [131] The introduction of the Altmark Package has been positive in a number of ways, not least in improving the predictability of State aid policy concerning compensation for SGEIs, as well as allowing a form of self-assessment in parallel with notification. In respect of hospitals specifically, however, it has failed to resolve previous difficulties and has, in practice, created several new problems. Sections 5 and 6 above show that there are long-standing issues in the internal market for healthcare which the Altmark Package, and specifically the 2005 Decision, served only to entrench, rather than address. These include the lack of transparency and control regarding the funding of the public hospital sector, the regular payment of overcompensation (including deficit compensation), and widespread cross-subsidisation.
- [132] The complaints and recent examples of market difficulties outlined in Section 6 above demonstrate that, far from decreasing since the 2005 Decision, these problems have been exacerbated. Complaints and litigation are being brought at both national and Community level. It is therefore likely to be only a matter of time before the EC courts are asked to consider the 2005 Decision and comment on its lawfulness both in principle, as a tool to extend the application of Article 106(2) TFEU, and in practice, through its implementation by Member States. As stated above, we submit that the 2005 Decision was based on an assessment of the internal market for healthcare that was inaccurate at the time, and is certainly inappropriate today. As part of the current review of State aid rules and SGEIs, the Commission has an opportunity now to assess these issues within the context of its own inquiry, rather than in judicial proceedings, and to resolve the current problems regarding the implementation of the Altmark Package.
- [133] UEHP recognises the particular sensitivity of hospital services and healthcare as a whole, but urges the Commission to take suitable steps to restore effective competition in the internal market for healthcare to the benefit of all stakeholders, taxpayers, consumers and patients. To this end, UEHP has set out below certain proposals for change.

The implementation of the 2005 Decision

Article 5(5) – Separate accounts

- [134] **Article 5(5) of the 2005 Decision, paragraph 19 of the Framework, and the Transparency Directive, all require beneficiaries to keep separate accounts for activities falling inside and outside the scope of the SGEIs they perform.** However, as with the checks on overcompensation discussed below, **there appears to be little or no evidence of this dual accounting taking place in the hospital sector.** UEHP is not convinced that the accounts of public sector hospitals that receive compensation are sufficiently transparent.
- [135] Transparency regarding the compensation paid to hospitals is an area in which shortcomings have been identified by private hospital associations in several Member States (see Sections 5 and 6). Transparency is vital for an effective assessment to be carried out to determine whether compensation granted to hospitals is adequately related to their costs, in order to prevent over-compensation and/or cross-subsidisation.
- [136] The Communication demonstrates that the principals of the Framework and the Transparency Directive can be applied, in practice, even in sensitive sectors. In paragraphs 60-63, the Communication reinforces the fundamental importance of the principle of transparency and the use of separate accounts.
- [137] The Communication outlines, at paragraph 60, that public service activities must be clearly separated from non-public service activities and that, in particular, this should include the separation of accounts. In this respect, the Communication re-states the requirements of the Transparency Directive:
- A beneficiary of public compensation must maintain separate internal accounts corresponding to different activities, i.e. public service and non-public service activities;
 - All costs and revenues must be correctly allocated on the basis of consistently applied and objectively justifiable cost-accounting principles; and
 - The cost-accounting principles according to which separate accounts are maintained must be clearly established.
- [138] The Communication also sets out in detail how costs should be allocated for accounting purposes, when they relate to both a broadcaster's public service and non-public service activities simultaneously.
- [139] Finally, the Communication notes that transparency will be increased if, in addition to separation of accounts, there is structural separation between a broadcaster's public service and non-public service activities. The Communication suggests that this could be achieved, for example, through separate management or separate companies/divisions within the broadcaster, each responsible for different activities.
- [140] While these provisions are aimed at the broadcasting market, there is no reason why they could not be applied equally to hospitals. The requirements set out in the Communication do not introduce new requirements, but rather restate established

principles set out in the Framework and Transparency Directive. The same principles should therefore be implemented fully by all Member States in the internal market for healthcare. Again, specific guidelines on this issue could be very beneficial in addressing current difficulties in the hospital sector, just as they have been in the broadcasting sector.

- [141] We would note, however, that requiring public hospitals to maintain separate accounts for their SGEI and non-SGEI activities may be a means of improving transparency, but will not in itself eliminate distortions of competition. In cases where there is inherent and systemic unfairness in the allocation of funding (for instance, in France), a requirement to keep separate accounts will expose this unfairness rather than remedy it. Further action must be taken to prevent over-compensation, in particular, in the first place.

Article 6 – Control of overcompensation

- [142] UEHP welcomes the content of Article 6 of the 2005 Decision. This requires that **Member States shall carry out regular checks, or procure that such checks are carried out, to ensure that undertakings are not receiving compensation in excess of the amount determined by Article 5, i.e. to check that no overcompensation is being paid.** Article 6 also sets out that Member States shall require any undertaking that has received overcompensation to repay the excess received.
- [143] UEHP does not believe, however, that all Member States have implemented this Article in practice. In particular, **UEHP is unaware of any evidence of Member States carrying out these checks, or of the Commission receiving information from Member States regarding the repayment of overcompensation.** There therefore does not appear to have been successful implementation of this Article at national level.
- [144] The control of overcompensation is a particularly important problem to address. Overcompensation inflates the healthcare budgets of Member States, provides State aid to recipients that gain a competitive advantage, reduces incentives for public hospitals to become more efficient (thus affecting the productivity of the healthcare sector as a whole), and directly leads to distortion of competition in the market.
- [145] The Framework includes provisions that specifically target overcompensation, in paragraphs 20-23. These state that Member States must carry out regular checks to ensure that there has been no overcompensation and, furthermore, describe how any such overcompensation should be dealt with. In particular, the Framework sets out specific provisions for the treatment of overcompensation which exceeds 10% of the amount of annual compensation received.
- [146] Similar provisions regarding overcompensation are set out in the Communication. Paragraphs 73-76 explain that broadcasters may retain yearly overcompensation above the net costs of the public service performed ("**Public Service Reserves**") to the extent that this is necessary to secure the financing of their public service obligations. In general, the Communication considers that overcompensation of up to 10% may be deemed necessary to withstand cost and revenue fluctuations. In some very limited cases, provided this can be duly justified, more than 10% overcompensation might be permitted. This remains the exception, rather than the rule, across the internal market.

- [147] The Communication also provides, at paragraph 23, a method for calculating reasonable compensation: the amount of public compensation granted must not exceed the net costs of the public service mission performed, taking into account other direct or indirect revenues derived from the public service mission, and allowance for a reasonable profit.
- [148] Finally, the Communication requires Member States to adopt appropriate mechanisms to prevent overcompensation. Member States must maintain regular and effective control of the use of public funding, to prevent overcompensation and cross-subsidisation, and scrutinise the level and the use of Public Service Reserves. The Communication suggests that this monitoring should be carried out by an external body, on a yearly basis.
- [149] **The Communication reiterates the practical steps that must be taken to ensure compliance with the Altmark Package.** The concepts introduced are not new, and they should apply to all sectors, not solely the broadcasting sector. In preparing the Communication, the Commission sought to address shortcomings in the implementation of the Altmark Package in the broadcasting sector by issuing sector-specific guidelines that restated the relevant provisions, and explaining how these provisions should be applied in practice. **UEHP respectfully submits that these steps can equally be applied to other sectors, and the practice of producing specific guidelines could be repeated in the hospital industry.**

Article 8 – Member State reporting requirements

- [150] Article 8 of the 2005 Decision is also welcomed by UEHP. **Article 8 requires Member States to submit periodic reports on the implementation of the 2005 Decision, containing a detailed description of the conditions of its application.** These reports are to be submitted by Member States to the Commission at least every three years (with the first such report due by 19 December 2008). **UEHP is unaware of any reports having been submitted, other than the contested report from Germany** (see paragraph [105] *et seq.* above).
- [151] This therefore appears to be another area in which the practical implementation of the 2005 Decision has not been effective. The substance of Article 8 is not being implemented at national level. Clear and detailed reports must be provided by Member States in order for the Commission to review not only the application of the 2005 Decision in practice, but also its effect on competition in the internal market for healthcare.
- [152] In conclusion, with regard to the current level of implementation of the 2005 Decision in the Community, and in particular in respect of Articles 5, 6 and 8, UEHP respectfully submits that the Commission should:
- Actively enforce these provisions in the internal market for healthcare;
 - Disclose the information reported by Member States to UEHP, its members and any interested third parties so that this can be verified independently; and
 - Take action against any *prima facie* evidence of overcompensation or cross-subsidisation.

Proposed changes to the 2005 Decision

- [153] In the preceding paragraphs, UEHP has detailed the failure of Member States to implement the 2005 Decision effectively in practice. However, UEHP believes that the 2005 Decision is not only failing in practice, but flawed in conception.
- [154] **UEHP proposes that the existing block exemption of State aid to hospitals should be removed, or a suitable cap should be introduced, so that compensation is assessed *ex ante* for compatibility with the common market** (see also paragraphs 38, 43 and 44 above). The scope of this assessment is already established by the 2005 Decision, the Framework and the Transparency Directive.
- [155] *Ex ante* assessment of compensation is essential in order to determine whether that compensation satisfies two key conditions of Article 106(2) TFEU, namely necessity and proportionality. Without an *ex ante* review of compensation granted to hospitals and adequate checks to ensure that overcompensation is not paid, there is no way of knowing that the compensation granted is either proportionate or necessary.
- [156] The removal of the block exemption under the 2005 Decision would address this risk by requiring that all funding of hospitals for their performance of SGEIs would be assessed under Article 106(2) TFEU, according to the principles set out in the Framework and the Transparency Directive.
- [157] Removing the block exemption would also encourage efficiency in public hospitals. Under the current system, the 2005 Decision allows compensation to be granted which covers the actual costs of the hospital entrusted with an SGEI, regardless of its efficiency. The judgement of the General Court in Case T-8/06 *FAB Fernsehen aus Berlin*, at paragraph 64, indicates that an assessment of efficiency, as described in the fourth *Altmark* criteria, should be one of the necessary criteria for any funding to benefit from the exception in Article 106(2) TFEU. Hence, such an efficiency assessment should be carried out in respect of funding granted to hospitals under the 2005 Decision. UEHP respectfully submits that, across the EU, Member States currently allocate funds to public hospitals without any regard as to whether they operate efficiently. The removal of the block exemption, and the more thorough implementation of the Framework, with a focus on the necessity and proportionality of compensation paid, could address this failure. Currently, by funding hospital deficits to an unlimited extent thanks to the uncapped exemption from notification granted by the 2005 Decision, Member States are not encouraging hospitals to act in an efficient, or even economically rational, manner.
- [158] The removal of the block exemption under the 2005 Decision is therefore UEHP's preferred solution to the problems which have been outlined in this paper.
- [159] As an alternative, the block exemption under the 2005 Decision could remain in place, but only for compensation below a specified cap. Under this system, any compensation paid to hospitals exceeding the cap would require notification to the Commission and assessment in line with the Framework; however, compensation below the cap would not have to be notified, provided that all of the other conditions of the 2005 Decision (including an efficiency assessment) are fulfilled.
- [160] A cap would allow for two tiers of verification. Compensation falling below the cap would be subject to lower standards of control, such as the submission of consolidated reports

every three years, while all amounts of compensation exceeding the cap would have to be individually assessed for compatibility *ex ante*. This *ex ante* assessment would consider the amount of funding awarded for the performance of SGEIs by a hospital, and the criteria used to calculate this amount, providing for a transparent means of awarding compensation based on merits and efficiency.

[161] This assessment could be undertaken by an independent national authority, in the manner set out in the Communication for the broadcasting sector, requiring each Member State to ensure that an effective reporting system was in place. In parallel, the Commission could retain the right to intervene *ex officio* and assess compensation to hospitals.

[162] Finally, if the Commission deems it necessary, which UEHP would endorse, **further legal certainty could be provided by adopting guidance on specific issues in this area**. A model is provided by the Communication, the principals behind which have already been applied in practice in several cases¹⁹. As noted above, specific provisions introduced in the broadcasting sector include, for example: effective controls and monitoring of overcompensation, including in respect of permitted reserves; prevention of cross-subsidisation through functional, structural and accounting separation; and reporting procedures and a system of dual review by national authorities and the Commission. The practical steps in the Communication that have already proved effective could be applied equally to the hospital sector, with such changes as necessary to reflect the specificities of healthcare, through the implementation of sector-specific guidance for hospitals.

[163] In addition, as suggested by BDPK, **an entrustment register could be set up to record all compensation paid by State bodies to hospitals**. This, together with an efficient system for *ex ante* assessment and *ex post* monitoring of the compensation granted, would prevent some of the recurring problems experienced in the implementation of the 2005 Decision so far, such as overcompensation and cross-subsidisation, which are so damaging to the hospital sector at present.

8. REQUEST FOR FURTHER INFORMATION AND DIALOGUE

[164] UEHP will continue to support the Commission in its efforts to address the distortion of competition in the hospital sector and, in particular, to address the inherent problems of applying the Altmark Package in practice.

[165] UEHP will actively encourage dialogue between its members and the Commission, with a view to avoiding, if possible, any further actions being brought for the time being and possibly solving, without further escalation, current claims and actions (including those that are dormant).

[166] In a similar spirit of cooperation, UEHP would welcome the opportunity to play a more active role in the Commission's investigation, market-testing and/or decision-making in this sector. UEHP suggests that a greater range of stakeholders should be involved in this process, including MEPs and representatives of other DGs e.g. DG SANCO. This would allow all interested parties to work together towards introducing a more efficient

¹⁹ For example, those brought in Austria, Finland and Germany

system of managing the public funding of hospitals, while at all times continuing to recognise the specific sensitivities of the sector.

[167] In order that its support of the Commission can be more effective and better informed, UEHP respectfully asks the Commission to provide it with the following documents, including in non-confidential or public versions as appropriate:

- The economic assessment carried out in 2005 which led to the conclusion, set out in the 2005 Decision, that the intensity of distortion of competition in the healthcare sector caused by State funding was not necessarily proportionate to the level of compensation granted;
- Any subsequent economic assessment(s) carried out in connection with the 2005 Decision in relation to compensation paid to hospitals;
- Member State submissions and reports on non-notifiable payments of State aid to hospitals filed with the Commission since 2005, with a particular focus on Italy, France and Belgium;
- Member State (and other stakeholder) submissions to the public consultation on the Altmark Package, again with a particular focus on Italy, France and Belgium; and
- The impact assessment that Article 9 of the 2005 Decision required the Commission to undertake before 19 December 2009 (if this was carried out).

[168] UEHP and its members believe that, by working with the Commission, a constructive and mutually-satisfactory outcome can be reached which prevents further disputes, and avoids any escalation of current complaints, to the benefit of all stakeholders, consumers and patients.

[169] We thank the Commission for its time in reviewing this paper. We would welcome the opportunity to discuss UEHP's views further, including at a meeting in person that we would be glad to arrange at your best convenience.