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Public Procurement Law and Health care: From Theory to Practice

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Public Procurement Law and Health care: From Theory to Practice⊕

Vassilis Hatzopoulos & Hélène Stergiou*

1. Introduction

Recent literature explores the impact of EU Law on national Health Care Systems through an analysis of the application of EU competition law, EU internal market law and EU state aid rules.[1] In this chapter the impact of the fast-growing field of EU Public Procurement rules on health care will be explored. Public procurement rules are a concrete expression of the fundamental freedoms, in particular the free provision of services (Art. 56 TFEU). According to settled case law, "the purpose of coordinating at Community level the procedures for the award of public contracts is to eliminate barriers to the freedom provide services and goods and therefore to protect the interests of traders established in a Member State who wish to offer goods or services to contracting authorities established in another Member State."[2] EU Public Procurement mainly consists of EU secondary law. Since the 1970's the EU has been regulating public procurement through directives in all of its Member States in order to accomplish a single market and remove restrictions on goods, services,

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⊕ A revised version of this text will appear in Van de Gronden, J., Krajewski, M., Neergaard, U. & Szyszczak, E. (eds) *Health Care and EU Law* (The Hague: Asser Press, forthcoming, 2010)

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[1] See, among many, a) for the impact of the internal market rules, V. Hatzopoulos, 'Killing national health and insurance systems but healing patients? The European market for health care services after the judgments of the ECJ in *Vanbraekel* and *Peerbooms*', *CMLRev* (2002), 683-729, and more recently 'Health law and policy, the impact of the EU', in De Burca (ed) *EU Law and the Welfare State: In Search of Solidarity* (Oxford, OUP/EUI, 2005), 123-160; G. Davies, 'Welfare as a service', *Legal Issues of European Integration* (2002) 27-40; P. Cabral, 'The Internal Market and the right to cross-border medical care', *ELRev*, (2004) 673-685, and A.P. van der Mei, 'Cross-border access to health care within the EU: Some reflections on *Geraets-Smits and Peerbooms* and *Vanbraekel'*, *Medical Law* (2002) 289-215 and 'Cross-border access to medical care: Non-hospital care and waiting lists', *Legal Issues of European Integration* (2004) 57-67; A. Dawes, 'Bonjour Herr Doctor: national healthcare systems, the Internal Market and cross-border medical care within the EU', *Legal Issues of European Integration* (2006), 167-182; b) for state aid see V. Hatzopoulos, 'Financing national health care in a trans-national environment: the impact of the EC internal market', *Wisconsin International Law Journal* 26:3 (2009) 761-804 and, by the same author, 'Public procurement and state aid in national healthcare systems', in Mossialos, E., Permanand, G., Baeten, R. and Hervey, T. (eds.), *Health Systems Governance in Europe: the role of EU law and policy* (Cambridge: CUP, forthcoming, 2010) ; c) for a full account of the relationships between EU and Health Law see T. Hervey and J. McHale, *Health Law and the European Union*, (Cambridge: CUP, 2004).

[2] E.g., Case C-380/98, *University of Cambridge,* [2000] ECR I-8035, para 16; Case C-19/00, *SIAC Construction,* [2001] ECR I-7725, para. 32; Case C-92/00, Hl, [2002] ECR I-5553, para. 43; and Case C-507/03, *Commission* v. *Ireland (An Post),* [2007] ECR I-9777, para. 27.

establishment and capital. However, it is not until recently that both the application and enforcement of EU Public Procurement Law has been rapidly expanding. In 2007 Public procurement accounted for an important proportion of economic activity – over € 2,000 billion or around 17% of EU GDP. [3] Local and cross-border competition in this area is delivering savings, with contracting authorities spending on average between 5-8% less than they had originally earmarked.[4] Both on a national and EU level the number of court cases is increasing. [5] The Commission has stepped up the efforts of monitoring compliance with public procurement law.[6]

The current developments with regard to the (potential) influence of EU public procurement on national health care systems are two-fold. On the one hand health care entities, such as hospitals and sickness funds, which qualify as contracting authorities under the procurement directives, may face the compulsory application of procurement rules while purchasing medical supplies, goods and services. On the other hand, following recent case law of the Court of Justice EU ('CJEU') a growing number of services escaping the full applicability of the directives – among which health care services - is subject to the transparency principle, under the condition that these services are of 'certain cross-border interest.'[7]

This contribution will focus on the core question if, how and to what extent the EU procurement rules and principles (may) affect the national health care systems. We start our analysis by summarizing the applicable EU public procurement legislation, principles and soft law and its exact scope in relation to health care. (section 2). Subsequently, we turn to the parties in a contract, subject to procurement rules in the field of health care, addressing both the definition of contracting authorities and relevant case law (section 3). This will then lead to an analysis of possible justifications for not holding a tender procedure in the field of health care (section 4). Finally, we illustrate the impact of EU public procurement rules on health care by analysing a Dutch case study, in which the question whether public hospitals in the Netherlands qualify as contracting authorities in terms of the Public Sector Directive stood central (section 5). Our conclusions will follow in section 6.

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[3] Http://ec.europa.eu/internal_market/publicprocurement/index_en.htm.
[4] *Ibid.*
[5] See also B.J. Drijber and H.M. Stergiou, 'Public Procurement Law and Internal Market Law'. *CML Rev.* 46, (2009) pp. 805-846, in which the "specialist" case law on public procurement is placed in the wider context of the "general" case law on the free provision of services.
[6] *Ibid.*
[7] Case C-324/98, *Telaustria,* [2000] ECR I-10745; Case C-59/00, *Vestergaard,* [2001] ECR I-9505; Case C-231/03, *Coname,* [2005] ECR I-7287; Case C-264/03, *Commission* v. *France,* [2005] ECR-I-8831; Case C-458/03, *Parking Brixen,* [2005] ECR I-8585; *Commission* v. *Ireland*, cited *supra* note 1; Case C-6/05, *Medipac-Kazantzides,* [2007] ECR I-4557 and Case C-220/06, *Asociación Profesional de Empresas de Reparto y Manipulado de Correspondencia v. Administración General del Estado (Correos)*, [2007] ECR I-12175, Joined Cases C-147/06 & C-148/06, *SECAP SpA and Santorso Soc. Coop. Arl* v. *Commune di Torino.*

2. Health care & EU Public Procurement: Rules and principles

The rules on contract award procedures are currently contained in two directives of 2004. Directive 2004/17/EC provides rules on the procurement procedures of entities operating in the water, energy, transport and postal services sectors (hereinafter: 'Utilities Directive').[8] For all other public contracts the rules are found in Directive 2004/18/EC (hereinafter: 'Public Sector Directive').[9] First, the scope of this Directive will be explored (2.1). Subsequently, the impact on health care services will be explored (2.2). Finally, relevant case law of the CJEU with regard to the applicability of the transparency principle to public health care services is discussed (2.3).

The scope of Directive 2004/18/EC

Directive 2004/18 does not explicitly regulate health care procurement. Depending on the nature and value of a contract, it should be tendered in accordance with the rules of the Directive. In other words, a public contract that *ratione materiae* falls under the scope of this Directive and the value of which exceeds the applicable financial thresholds must be tendered by a contracting authority in accordance with the Directive. Public contracts are divided into three main categories: public service contracts, public works contracts and public supply contracts. The Directive does not define public services.[10] For the purposes of the Directive, the meaning of services is very wide. All services are covered. It includes all 'public contracts other than public works or supply contracts having as their object the provisions of services referred to in Annex II of the directive.'[11] However, a distinction is made between Part A and Part B-services. The threshold values have been set at levels, which are intended to reflect those contracts which are likely to attract bidders from other Member States.[12] Currently, the threshold for the award of service contracts by government departments and entities closely associated with these departments lies at € 125.000. For contracting authorities, such as

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[8] Directive 2004/17/EC on the coordination of the procurement procedures of entities operating in the water, energy, transport and postal services sectors (*OJ* 2004, L 134/1*).*

[9] Directive 2004/18/EC on the coordination of procedures for the award of public works contracts, public supply contracts and public service contracts **(***OJ* 2004, L 134/114).

[10] In its Guide to the Community rules on public procurement of services, the Commission states: 'Within the meaning of the EC Treaty services are considered to be services where they are normally provided for remuneration, in so far as they are not governed by the provisions relating to the freedom of movement for goods, capital and persons.' See Guide to the Community rules on public procurement of services other than in the water, energy, transport and telecommunications sectors. Directive 92/50/EEC, p.5. This approach is in line with settled case law of the CJEU, in which the Court has held that Article 56 TFEU (old Article 49 EC) is applicable to services normally provided for remuneration. Case 263/86 *Humbel* [1988] ECR 5365, para. 17 and case C-157/99 *Smits and Peerbooms* [2001] ECR I-5473, para. 58.

[11] Article 1(2)(d) Public Sector Directive.

[12] New thresholds entered into force on 1 Jan. 2010. See Regulation (EC) No. 1177/2009, amending Directives 2004/17/EC and 2004/18/EC in respect of their application thresholds for the procedures for the award of contracts (*OJ* 2009, L 314/64*).*

regional and local authorities, the Directive applies to all Part A services contracts with a value equal or greater to € 193.000.[13]

A number of public contracts are excluded from the scope of the Public Sector Directive. This Directive does not apply, for example, to below-threshold contracts, to secret contracts and contracts requiring special security measures (Art. 14), employment contracts, research and development services, financial services (Art. 16), service concessions (Art. 17) or service contracts awarded on the basis of an exclusive right (Art. 18). A general provision in the Directive exempting health care from the application of the Directive does not exist. However, recital 6 of the Directive states that 'Nothing in this Directive should prevent the imposition or enforcement of measures necessary to protect public (…) health, human and animal life (…) provided that these measures are in conformity with the Treaty.'

A light procurement regime for health care services under Directive 2004/18/EC

Health care services are in principle covered by the Public Sector Directive. However, they are listed in Annex II B of the Directive and therefore a special 'light' procurement regime applies.

Since the adoption of the Directive 92/50/EEC on the coordination of procedures for the award of public service contracts[14] (now consolidated and amended by the Public Sector Directive), a so-called 'two-tier' approach exists towards the procurement of public service contracts. This approach was maintained in the Directives of 2004.[15] This means that the Public Sector Directive applies in its entirety only to contracts designated as 'Part A- service contracts' also referred to as contracts for 'priority services'.[16] In effect, these services were identified as being of priority interest from the point of view of development of cross-border operations.[17] In other words, Part A-services are those on which the open market regime is likely to have the most impact (and conversely), taking into account factors such as the potential for cross-border trade, economic importance and likely savings.[18] The services,

[13] Article 7(b) first indent Public Sector Directive.

[14] Council Directive 92/50/EEC of 18 June 1992 relating to the coordination of procedures for the award of public service contracts as amended by Directive 97/52/EC.

[15] In its review of the Services Directive 92/50/EEC under Article 43 of that Directive, the Commission was obliged within three years of adoption to consider applying all the provisions of the Directive to Part B-services and make proposals for adapting the Directive. But no changes had been made since the adoption of the Services Directive. During the legislative process of the new Directives no revision took place and no proposals were made. According to an EC Commission official, Member States were at that time reluctant to discuss a more "liberalised" regime of Part B-services.

[16] Annex II A of the Directive covers, *inter alia*, maintenance and repair of equipment and vehicles, some transport services, financial services, computer services, research and development for the authority's own purpose, accounting services, management consultancy, computer services, architectural and planning services, advertising, building cleaning and property management, publishing and printing and sewerage and sanitation services.

[17] Guide to the Community rules on public procurement of services *supra* n. 10, p.7.

[18] Recital 21 of Services Directive 92/50/EEC. See also S. Arrowsmith, *The Law of Public and Utilities Procurement* (Sweet & Maxwell 2005), p. 314, para. 6.44.

including health care services, listed in Annex II B ('non-priority services' or 'Part B services'), do fall within the scope of the Directive but they are subject to a 'light' procurement regime, which only requires a) non-discriminatory technical specifications to be used in the tendering documents (Art. 23) and b) the *ex post* publication of the results of the award (Art. 35(4)).[19] It is therefore in principle lawful to grant Part B-service contracts without organizing any form of procurement procedure.[20] This light Part B-regime has been based on the assumption that from an internal market perspective the services in question have no priority in terms of establishing the internal market. These types of services are considered to be less capable of attracting international competition either because of the nature of the services (for example: legal and administrative services which are based on familiarity with national laws and jurisdictions) or because of the location in which they are provided (hotel and restaurant services). In these categories of services it was considered necessary merely to give service providers the minimum information necessary to explore the market, and to create an information base which would permit informed judgments to be made about possible application of the procedural and other rules of the Services Directive to some or all of these categories.[21]

In order to further assess which health services are included in Annex II B, one has to look at the applicable categorization and sub categorization. Health care services are grouped in category 25 of Annex II B, together with social work services. The following main categories of health services are, based on the Common Procurement Vocabulary (CPV) 2008, included in category 25 of Part B:

85100000-0 Health services

85110000-3 Hospital and related services
85120000-6 Medical practice and related services
85130000-9 Dental practice and related services
85140000-2 Miscellaneous health services
85150000-5 Medical imaging services
85160000-8 Optician services
85170000-1 Acupuncture and chiropractor services

[19] Article 21 Public Sector Directive.
[20] Annex II B to the Directive lists eleven categories of public services, which are subject to a 'light' procurement regime. The following services are currently included in Annex II B: hotel and restaurant services, rail and transport services, water transport services, supporting and auxiliary transport services, legal services, personal replacement and supply services, except employment contracts, investigation and security services, except armoured car services, education and vocational education services, health and social services, recreational, cultural and sporting services and other services, except contracts for the acquisition, development, production or co-production of programmes by broadcasting organisations and contracts for broadcasting time. A service falls in the last category "other services" only in the exceptional case where it is not possible to place it in any of the categories of Annex IIA or Annex IIB.
[21] See Guide to the Community rules on public procurement of services, *supra* n. 10, p. 9.

The CPV, adopted by Regulation (EC) No. 213/2008 is in use since 17 September 2008 and consists of a main vocabulary for defining the subject matter of a contract, and a supplementary vocabulary for adding further qualitative information. The main vocabulary is based on a tree structure comprising codes of up to 9 digits (an 8 digit code plus a check digit) associated with a wording that describes the type of services forming the subject of the contract. As indicated on the website of the EU, the use of the CPV is mandatory in the European Union as from 1 February 2006: 'Contracting authorities should try to find the code that suits their envisaged purchase as accurately as possible. Although in some occasions contracting authorities may find themselves having to select several codes, it is important that they select a single code for the title of the contract notice.'[22]

In case a service falls both within Annex II A and II B or a public contract has as its object both products and services within the meaning of Annex II, it must be considered a Part B-public service contract if the value of the services in question exceeds that of the products or the Part A-services covered by the contract.[23] In such cases the general rule applies, that it is not possible to avoid the application of the Directives by including the service in a contract, which for some reason would not be subject to the Directive.[24] It is, therefore, necessary to examine whether the contracting authority could have split the transactions into separate contracts, one or more of which would have been subject to the Directives.[25] So, in assessing whether Part A and Part B services are artificially packed together or split up, the intention of the contracting authority in a specific case should be scrutinized. 'If the services naturally combine to achieve a single purpose, then splitting them up would be artificial (…). On the other hand, if the services do not naturally combine to achieve a single purpose, then packaging them together (where the value of the non-priority services is greater) would be artificial.'[26]

This has also been the approach by the Court in the *Tögel* case on health care services.[27] In this case an integrated service contract was at stake (services consisting in the transport of injured and sick persons with a nurse in attendance), which involved some components covered by Part A (land transport services) and some by Part B (ambulance services). The Court ruled with reference to Article 9(3) of the Directive that it is prohibited to artificially group in one contract both Part A and Part B services 'without there being any link arising from the a joint purpose or operation', with the sole purpose of increasing the proportion of Part B services and thus avoiding the full application of the Directive. According

[22] http://simap.europa.eu/codes-and-nomenclatures/codes-cpv/codes-cpv_en.htm.
[23] Article 7(a)(b) Public Sector Directive.
[24] Article 9(3) of the Directive prohibits the artificial splitting of contracts for the purpose of avoiding the application of the Directive.
[25] See Guide to the Community rules on public procurement of services, *supra* n. 10, p.12.
[26] P.Trepte, *Public Procurement in the EU. A Practioner's Guide,* (Oxford University Press, 2007), pp. 230-231, para. 4.98.
[27] Case C-76/97 *Walter Tögel* v. *Niederösterreichische Gebietskrankenkasse* [1998] ECR I-5357.

to the Court not only the artificial splitting, but also the artificial grouping of contracts is prohibited.

Arrowsmith has criticized the 'greater value rule' for facilitating circumvention of the full procurement regime of Part A services in the case that Part A services are of a value above the threshold, but the Part B services are of greater value. In that way the Part A services are exempted from the full regime, although the rules would apply if the Part A services were purchased separately.[28] However, in the *Felix Swoboda* case[29] the Court decided that there does not exist an obligation for the contracting authority to separate in that case the Part B-services from the Part A-services and to award separate contracts in respect of them.

General principles applicable to the award of health care services: Change of procurement regime following the Transparency case law?

When assessing the impact of EU Public Procurement Law on national health care systems, general principles of law applicable to the award of health care services should be taken into account. The Treaty contains general rules that prohibit Member States from discriminating against the undertakings of other Member States and that also forbid other barriers to market access (Art. 34 TFEU –old Art. 28 TEC-, Art. 45 TFEU – old Art. 39 TEC- and Art. 56 TFEU –old Art. 49 TEC). By the same token, recital 2 of the Directive states that "the award of contracts concluded in the Member States on behalf of the State, regional or local authorities and other bodies governed by public law entities, is subject to the principles of the Treaty and in particular to the principle of freedom of movement of goods, the principle of freedom of establishment and the principle of freedom to provide services and to the principles deriving there from, such as the principle of equal treatment, the principle of non-discrimination, the principle of mutual recognition, the principle of proportionality and the principle of transparency."[30] Under the Directive, therefore, it is lawful to grant health care services and other Part B-service contracts without organizing any form of procurement procedure. However, the Court, in a series of fairly recent judgements ('*Transparency* case law') has decided that the award of excluded public service contracts, such as Part B-services, must respect the principle of transparency, as a means of ensuring equal treatment of potentially interested parties.[31] The 'light' procurement regime of health care services has been mostly affected by this case law.

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[28] S. Arrowsmith, *supra* n. 18, p. 315, para. 6.47.

[29] Case C-411/00*, Felix Swoboda GmbH v Österreichische Nationalbank* [2002] ECR I-10567.

[30] Furthermore, Article 2 of the Public Sector Directive stipulates that operators can benefit from opportunities in other Member States by stating that Member States have to comply with the principles of non-discrimination and transparency when awarding public contracts.

[31] The equal treatment principle in relation to public procurement was first mentioned in Case C-243/89, *Commission* v*. Denmark (Storebaelt),* [1993] ECR I-3353, para. 33. It was further developed in Case C-21/03, *Fabricom* v. *Belgian State,* [2005] ECR I-1559, para. 14. The principle of equal treatment entails an obligation of transparency. See, for the first time, Case C-275/98, *Unitron Scandinavia and 3-S,* [1999] ECR I-8921, para. 31.

In the cases *Telaustria, Coname* and *Parking Brixen* the award of service *concessions* stood central.[32] Service concessions, i.e. the situations where the service providers do not get fully paid by the contracting authority for their services, but are remunerated by the users, thus participating to the operational risk of the services offered, are not covered by the Directive.

According to the Court, in *Telaustria,* the first of this series of judgments, transparency 'consists in ensuring for the benefit of any potential tenderer, a degree of advertising sufficient to enable the services market to be opened up to competition and the impartiality of the procurement process to be reviewed.'[33] Unfortunately, the Court did not specify what kind or degree of publicity is necessary; for example, whether it is sufficient to publish an announcement for a list of approved suppliers or if publicity must be Europe-wide.[34] Nor was it clear whether 'a sufficient degree of advertising' implies an obligation to tender. It was not until 2005 that the Court had an opportunity to clarify what "a sufficient degree of advertising" actually means. In *Coname,* it held that transparency does not necessarily involve 'an obligation to hold an invitation to tender.'[35] Rather it implies that the contracting authority is obliged to ensure that an undertaking located in the territory of another Member State has access to appropriate information regarding the concession before it is awarded. In other words, the contracting authority must ensure that any interested party has the opportunity to manifest its interest, but a procedure in accordance with the Directives is not required. In the next relevant ruling, *Parking Brixen*, the Court stressed that some kind of call for competition is necessary: '(…) a complete lack of any call for competition in the case of the award of a public service concession such as that at issue in the main proceedings does not comply with the requirements of Articles 43 EC and 49 EC any more than with the principles of equal treatment, non-discrimination and transparency.'[36] Again, it was clear that doing nothing was not enough, but unclear what a contracting authority should positively be doing to satisfy the transparency principle.[37] In 2006 the Commission issued, following the *Transparency* case law up until *Parking Brixen*, an Interpretative Communication on the Community law applicable to contract awards not or not fully subject to the provisions of the Directives. [38] According to the Commission, in order to comply with the obligation to ensure adequate

[32] *Telaustria*, *supra* n. 7, para. 62, Case C-231/03, *Coname*, [2005] ECR I-7287 and Case C-458/03, *Parking Brixen*, [2005] ECR I-8585.

[33] *Telaustria*, *supra* n. 7, para. 62.

[34] Arrowsmith, *supra* n. 18, p. 366.

[35] *Coname*, *supra* n. 32.

[36] *Parking Brixen*, *supra* n. 32, para. 50.

[37] Public authorities had expressed a need for clarification of the obligations deriving from the principle of openness, since the application of this principle is subject to interpretation. The vagueness of the obligations on how to act had been experienced problematic. See Social Services of General Interest: Feedback Report to the 2006 questionnaire of the Social Protection Committee, p. 10-12, available at: http://ec.europa.eu/employment_social/spsi/docs/social_protection/2008/feedback_report_final_en.pdf.

[38] Interpretative Communication on the Community law applicable to contract awards not or not fully subject to the provisions of the Directives (*OJ* 2006, C 179/2).

advertising, the advertising should mention the 'essential details of the contract to be awarded and of the award method' and 'should provide as much information as an undertaking from another Member State will reasonably need to make a decision on whether to express its interest in obtaining the contract.' In view of the vagueness of the Commission's formulation it comes as no surprise that Member States were left with numerous questions unresolved.[39] An obvious antinomy lies on the fact that the Directive, an instrument of hard law, specifically submits Part B- services to the 'light' procurement regime, while the Communication, through the back door (i.e., Articles 49 and 56 TFEU and the principle of transparency) imposes on them a much heavier procedural burden.[40]

The Commission's position, nonetheless, has been confirmed by the Court in its landmark case, *Commission v. Ireland (An Post)*. In this case the Court further spelled out the requirements of transparency limiting, by the same token, the scope of their application. The Court dealt with the question whether the award of a Part B- service contract to An Post concerning payments under social benefit schemes, without any prior advertising, was contrary to the EC Treaty.[41] The Court considered that service contracts come within the scope of Treaty provisions on free movement only when these contracts present 'certain cross-border interest' to an undertaking located in another Member State. It held that these provisions are breached if such undertaking 'was unable to express its interest in that contract because it did not have access to adequate information before the contract was awarded.' The Court seems to focus on the likelihood that a company established in another Member State would have been interested in making an offer, had it been properly informed about the public contract through any form of advertisement. In the framework of an action against a Member State it is for the Commission to show that the criterion of "certain cross-border

[39] See also McGowan, 'Clarity at last? Low value contracts and transparency obligations', 16 *PPLR* (2007), pp. 274-283. The Commission has been criticized by several Member States and the European Parliament for creating new rules on tendering, which go beyond the current obligations under Community law. Germany challenged the legality of the Communication (Case T-258/06, *OJ* 2006, C 294/52, pending).

[40] See also Interpretative communication on the application of Community law on Public Procurement and Concessions to institutionalized PPP (IPPP) *(OJ* 2008 C 91/02), in which the Commission emphasizes the application of 'the principle of equal treatment and the specific expressions of that principle, namely the prohibition of discrimination on grounds of nationality and Articles 43 TEC on freedom of establishment and 49 TEC on freedom to provide services' when choosing a third party for the supply of economic activities. See also Communication on Mobilising private and public investment for recovery and long term structural change: developing Public Private Partnerships, COM (2009) 615 final, p. 5, para. 3.1.

[41] *An Post*, cited *supra* note 2. In a similar infringement procedure between the Commission and Ireland, the Court was asked to assess whether Ireland had failed to fulfil its obligations on the principle of transparency. The Dublin City Council ("DCC") had awarded a Part B-service contract to provide emergency ambulance services to the Eastern Regional Health Authority without undertaking any prior advertising, Case C-532/03 *Commission v Ireland (Ambulance Services)* [2007] ECR I-11353. See for a case note, Browne in 17 *PPLR* (2008), pp. 92-95.

interest" is fulfilled.[42] In the case of *An Post*, the CJEU found that the Commission had not provided the required evidence and the Commission's application was dismissed.[43] It is unclear how this finding will affect the onus of proof in disputes between individuals. The ruling in *SECAP* explains further the exact meaning of "certain cross-border interest":[44] 'in view of its particular characteristics, a given contract is likely to be of certain cross-border interest and therefore attract operators from other Member States.'[45] This depends, amongst other things, on 'the estimated value [of the contract] in conjunction with its technical complexity or the fact that the works are to be located in a place which is likely to attract the interest of foreign operators.'[46]

This recent development on the application of the transparency obligation has raised certain practical questions: What is the meaning of the adverb 'certain?' How should a certain cross-border interest be established? Does a public authority have a *duty* to assess whether the contract in question presents 'certain cross-border interest?' Obviously, there is not one single circumstance that determines whether a given contract is of certain cross-border interest. The test is inevitably a very factual one.[47] One conclusion can be drawn: depending on the individual characteristics of a public service contract, this case law on transparency could lead to an obligation to advertise health care services and, possibly, to full application of the Directive.

Whether a health care service is of 'certain cross-border interest' will highly depend on the size and estimated value of the contract. Further, the complexity of the contractual obligation, requiring a high degree of expertise unlikely to be found at the local level, would justify interest from other Member States. Moreover, it is considered that a contract, which is performed in a border region, attracts foreign service providers.[48] For example, a contract to provide ambulance services in the southern region of the Netherlands, with an estimated value of € 300 million a year, will probably attract the attention of German and Belgian ambulance service providers. In that case it is advised to organise a procurement procedure in accordance with the Directive. However, a supply contract with an estimated value of € 42.000, to deliver medical supplies to a middle-sized hospital in the Dutch city of Abcoude, will probably, based on its value and geographical characteristics, not qualify as a contract of

[42] *An Post*, at para 33: 'According to settled case law, it is the Commission's responsibility to provide the Court with the evidence necessary to enable it to establish that an obligation has not been fulfilled and, in so doing, the Commission may not rely on any presumption.'

[43] In *Commission v. Italy* the CJEU applied the same reasoning to contracts whose value falls below the thresholds of the Directive. Case C-412/04, *Commission* v. *Italy*, [2008] ECR I-619.

[44] *SECAP SpA and Santorso Soc. Coop. Arl* v. *Commune di Torino*, cited *supra* n.4.

[45] *Ibid* para. 24.

[46] *Ibid* para. 24.

[47] See also Drijber and Stergiou, *supra* n. 5, pp. 809-815.

[48] Due to the mobility of service providers and service recipients active in these markets, the dynamics of this service market has changed and they are considered to be, from a service recipient perspective, increasingly of cross-border interest. The case law on patient's rights to cross-border health care, shows that patients are willing to travel in order to undergo treatment in another Member State. See for example Case C-444/05 *Stamatelaki*, [2007] ECR I-3185 and Case C-372/04 *Watts*, [2006] ECR I-4325.

"certain cross-border interest".[49] Future case law is expected to flesh up the criteria in order to determine which health care services are of 'certain cross-border interest.'In the meanwhile, it is difficult to draw a general conclusion with regard to the question to what extent the EU procurement rules and principles currently affect the national health care systems. As indicated above, this currently depends on the individual characteristics of every single public contract concerning health.

3. Entities in health care subject to EU public procurement rules and principles

Public Procurement rules and principles only bind on contracting authorities - other entities are subject to the principle of contractual freedom. The qualification of any entity as being a contracting authority is a highly controversial issue – the more so in the field of healthcare (3.1). In this respect, the enumeration, by Member States, in Annex III of the Directive, of entities they deem to be contracting authorities, is of little help (3.2). The same may be said for the Court's case law concerning the qualification of contracting authorities in the field of healthcare (3.3)

The concept of a contracting authority

The entities covered by the Directive fall within two broad categories: (i) the State, regional or local authorities (public authorities), associations formed by one or several of such authorities; and (ii) bodies governed by public law and associations formed by one or several of such bodies governed by public law.[50] All health care entities, which are part of the State, regional or local authorities, are subject to the Directive. Annex IV to the Directive consists per Member State of a non-exhaustive list of central government authorities. Moreover, Annex III contains a non-exhaustive list of 'bodies governed by public law.' The content of both Annexes will be further discussed in paragraph 3.2.

For all other entities active in the area of health care, but not included in Annex III, their qualification as contracting authorities is not automatic. The specific legal and factual situation pertaining to each such entity should be scrutinized in order to determine whether it qualifies as 'a body governed by public law.' This category of contracting authorities is subject to three cumulative criteria, which have generated an extensive body of case law.

First the organisation must be established for the *specific purpose of meeting needs in the general interest, which do not have an industrial or commercial character.* With regard to the first part of this criterion, it has been considered that this definition excludes entities, which are subject to commercial pressure to purchase efficiently.[51] This applies to public

[50] Article 1(9) Public Sector Directive.
[51] Case C-44/96 *Mannesmann Anlagenbau Austria AG and Others* v. *Strohal Rotationsdruck GmbH* [1998] ECR I-73.

entities providing goods and services in a competitive market.[52] Entities providing services directly to the public often meet needs in the general interest.[53] According to the Court, needs in the general interest are those which for reasons associated with the general interest, the state chooses to provide itself or over which it wishes to retain a decisive influence.[54] The definition of the term 'needs in the general interest' has been interpreted very widely. Activities in the field of waste collection and the cleaning of a municipal road network[55], as well as the activity of a funeral undertaker[56] have all been considered by the Court to meet needs in the general interest. These types of activities can be linked to a public policy or public interest such as hygiene and public health. If an activity does meet needs in the general interest, it falls then to be considered whether these needs have an industrial or commercial nature. In applying this test the CJEU has mainly focussed on the question whether the entity carries out the activity on a commercial basis.[57] In that respect the Court examines both the characteristics of the marketplace in which the entity operates (in competition with other undertakings, which can influence its commercial behaviour, commercial side-activities), and the nature of the entity itself.

The second criterion that an entity needs to satisfy in order to qualify as a body governed by public law under the Directive is the existence of *legal personality.* This requirement has not provoked any great amount of legal debate. The Court has constantly held that it is irrelevant whether the entity in question has been established
under private or public law.[58]

Third, the Directive applies to entities which must are either *financed* or *supervised* or *appointed* by another contracting authority. This condition is used primarily to determine the degree of dependency of the entity in question from the state and the degree of state control. The condition is satisfied where any of the three criteria is met. The term 'financed for the most part' means, according to the judgment in *Cambridge*, more than the half and is to be re-appraised constantly.[59] There is no requirement that the activity of the bodies in question should be directly financed by the State or by another public body; the Court has held indirect

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[52] Arrowsmith, *supra* n. 18, pp. 264-265, para. 5.10.

[53] *Ibid* p. 266, para. 5.11.

[54] Case C-323/96, *Vlaamse Raad* [1998] ECR I-5063, paras. 50-51 and Joined Cases C-223/99 and C-260/99 *Agorà Srl and Excelsior Snc di Pedrotti Bruna & C.* v. *Ente Autonomo Fiera Internazionale di Milano and Ciftat Soc. Coop. arl* [2001] ECR 3606, para. 37.

[55] Case C-360/*96 Gemeente Arnhem and Gemeente Rheden* v *BFI Holding BV* [1998] ECR I-6821.

[56] Case C-373/00 *Adolf Truley GmbH v Bestattung Wien GmbH* [2003] ECR I-1931.

[57] Arrowsmith, *supra* n. 18, p. 269, para. 5.14.

[58] Case C-214/00 *Commission* v. *Spain* [2003] ECR I-4667, Case C-283/00 *Commission* v. *Spain* [2003] ECR I-11697, Case C-84/03 *Commission* v. *Spain* [2005] ECR I-139. See for an analysis of these cases: Trepte, *supra* n. 26, p. 119-121, paras 2.56-2.59.

[59] Case C-380/98 *The Queen v HM Treasury Ex p. Cambridge University* [2000] ECR 8035, para. 30. See also Article 2 of Directive 2006/111/EC on the transparency of financial relations between Member States and public undertakings ('Transparency Directive'), *OJ* L 318.

financing to be sufficient.[60] The managerial dependency condition concerns the direct participation of public authorities and officials in the management of the entity. According to the Court in *Commission v France* it is necessary to consider whether the controls over the entity make them 'dependent on the public authorities in such a way that the latter are able to influence their decisions in relation to public contracts.'[61] In this specific case in which an entity was responsible for providing social housing in France, the Court decided that this condition was met in view of the fact that a) the activities were highly regulated, b) the Ministers for finance and construction exercised broad supervisory powers and c) the responsible Minister had the competence to suspend the management and appoint a liquidator or administrator. The Court has ruled in *Adolf Truly* that the condition of 'supervisory dependency' is satisfied where the public authorities supervise not only the annual accounts of the body concerned but also its conduct from the point of view of proper accounting, regularity, economy, efficiency etc. [62] In *Commission v France* the Court held that a degree of management supervision is necessary, which permits the public authorities to influence or interfere with the procurement procedures.[63] The Court has described these three alternative criteria of finance, management supervision and appointment as embodying a relationship of close dependency on a contracting authority.[64]

Only recently has the Court been asked to apply the abovementioned criteria to entities active in the field of health care. In case *Oymanns*, the Oberlandesgericht Düsseldorf asked the Court, *inter alia*, whether the German statutory sickness insurance funds constitute contracting authorities for the purposes of the application of the rules in the Directive.[65] While the first two conditions were fulfilled in this case, the extent to which the funds were financed/supervised/appointed by the State had to be ascertained. Unfortunately, the Court only interpreted 'financed for the most part', since it consider this condition to be fulfilled in this specific case: '[…] when the activities of statutory sickness insurance funds are chiefly financed by contributions payable by members, which are imposed, calculated and collected according to rules of public law.'[66] The Court takes into consideration the fact that the sickness funds in question are financed, for the most part, by compulsory contributions from members [67] for which (contributions) no specific consideration is provided in return:[68] 'no contractual consideration is linked to those payments, since neither the liability to pay contributions nor their amount is the result of any agreement between the statutory sickness insurance funds and their members, since membership of the funds, and payment of

[60] Case C-337/06 *Bayerischer Rundfunk and Others* [2007] ECR I-11173, paras, 34 and 49. See also Arrowsmith, *supra* n. 18, p. 257, para. 5.6.
[61] Case C-237/99 *Commission v France* [2001] ECR I-939.
[62] *Adolf Truley supra* n. 56, paras. 71-74.
[63] *Commission v France, supra* n. 61, para. 59.
[64] *Mannesmann supra* n. 51, para. 20 and *University of Cambridge, supra* n. 53, para. 74.
[65] Case C-300/07 *Hans & Christophorus Oymanns*, judgement of 11 June 2009, nyr.
[66] *Ibid* para. 59.
[67] *Ibid* para. 52.
[68] *University of Cambridge, supra* n. 59, para. 74.

contributions, are both required by law.'[69] In that respect the Court considers that the amount of contributions is based solely on the capacity to contribute of each member, whereas other factors, such as the age of the insured persons, their state of health or the number of co-insured persons are irrelevant in that regard. This, together with the fact that (i) the setting of the contribution rate by the statutory sickness insurance funds requires, in any event, the approval of the public body which supervises each fund, (ii) the funds' other sources of revenue, the direct payments by the federal authorities, although of a smaller amount, are unquestionably direct financing by the State and (iii) the conclusion that contributions are compulsorily recovered on the basis of the provisions of public law, amounts to a situation, in which there is financing, for the most part, by the State.[70]

Member States' lists on contracting authorities unhelpful

Annex III of the Directive lists per Member State bodies and categories governed by public law. Annex IV to the Directive consists per Member State of a non-exhaustive list of central government authorities. Both lists contain contracting authorities and entities that have to apply EU public procurement rules. From national ministries to local councils, from schools to universities, but also hospitals, airports, railway operators, museums, postal entities, urban transport, water utilities and national lotteries. These lists are are non-exhaustive and only have indicative value,[71] while the exact scope of the Directive remains defined by the Court's case law. Therefore it cannot be ruled out that entities listed in one of these annexes are 'disqualified' in the course of court proceedings. Especially, since it has been up to the Member States themselves to enumerate in a non-exhaustive manner the entities they consider to be subject to the Directive and no mechanism for regular revision by the Commission is in place. A fine example is case *Oymanns*, in which the question was raised whether German sickness funds are contracting authorities, despite the fact that these funds are expressly listed in Annex III. The German court raised, although not explicitly, a question concerning the validity of the inclusion in the list in Annex III of these funds.[72] Nonetheless, according to the Commission, the lists intend to 'give citizens and businesses the opportunity to identify which public authorities in the EU have to submit their public contracts to EU-wide tender procedures. As well as improving accountability and transparency in this area, the updated lists are intended to offer more opportunities for business to participate in public contracts.'[73] By Decision of 9 December 2008 the Commission has updated both annexes

[69] *Oymanns supra* n. 65, para. 53.
[70] *Ibid* paras. 54-58.
[71] http://ec.europa.eu/internal_market/publicprocurement/authorities_en.htm.
[72] *Oymanns supra* n. 65, para. 46.
[73] http://europa.eu/rapid/pressReleasesAction.do?reference=IP/08/1971&format=HTML&aged=0&language=EN&guiLanguage=en.

(including the 'new' Member States).[74]

A comparison of the national lists shows a very wide variety of perceptions concerning the qualification of contracting authorities in the field of health care.[75] Some Member States have submitted their list exclusively in their official language (Bulgaria, Czech Republic, Estonia, Cyprus, Hungary, Malta), thus cancelling the 'transparency' function of the lists. Others have not listed any body or entity in the field of healthcare (Luxemburg, Denmark), while others merely refer to (parts of) the definition of Article 1(9) of the Directive (Portugal, Slovakia). In practice, therefore, the usefulness of the lists is quite limited, as any helpful comparison is difficult to be carried out. A list of bodies/categories of thirteen Member States, illustrates this problem:[76]

- Austria considers all bodies under the budgetary control of the 'Rechnungshof' (Court of Auditors) except those of an industrial or commercial nature to be a contracting entity.
- In Belgium six public hospitals and three sickness funds are indicated as contracting authorities. Private hospitals are not mentioned.
- In France there is one specific health insurance (Caisse nationale militaire de sécurité sociale (CNMSS)) and all public hospitals listed as contracting authorities.
- In Germany social security institutions, such as health, accident and pension insurance funds and hospitals, health resort establishments, medical research institutes, testing and carcass disposal establishments are indicated as contracting authorities.
- Greece gives only a broad definition of all entities controlled by over 51% of the State.
- Ireland has used the following qualification: 'Hospitals and similar institutions of a public character and agencies established to carry out particular functions or meet needs in various public sectors [e.g. Healthcare Materials Management Board (…) etc.] and Health Service Executive (organization responsible for providing Health and personal services for Irish citizens.).'
- In Italy agencies administering compulsory social security and welfare schemes, public welfare and benevolent institutions (and, more general, organizations providing services in the public interest are qualified as contracting authorities. Hospitals are not mentioned.
- The Netherlands has indicated the former sickness funds as contracting authorities,

[74] Commission Decision of 9 December 2008 amending the Annexes to Directives 2004/17/EC and 2004/18/EC of the European Parliament and of the Council on public procurement procedures, as regards their lists of contracting entities and contracting authorities. 2008/963/EC. For the sake of transparency and accountability in public procurement the Commission has replaced references to national laws by the actual names of contracting authorities. In doing so the Commission intends to give citizens and businesses the opportunity to better identify which public authorities in the EU have to submit their public contracts to EU-wide tender procedures and offer more opportunities for business to participate in public contracts.

[75] See also V. Hatzopoulos in Draft conference paper: 'Health Systems Governance in Europe: the Role of EU Law and Policy: Public Procurement and State Aid in National Health Care Systems', pp. 177-178.

whereas it has privatized its health system from 1st of January 2006. Furthermore the Netherlands enumerates several bodies involved in the management of hospital facilities and accreditation of health providers. Academic hospitals, which are generally considered to be contracting authorities, are not mentioned.

- In Poland 'Public Autonomous Health Care Management Units whose founding body is a regional or local self-government or association thereof' are mentioned. There is no reference made to hospitals or sickness funds.
- In Romania hospitals, sanatoria, clinics, medical units, legal-medical institutes, ambulance stations are listed as contracting authorities.
- Slovenia has taken a broad approach by indicating that all public institutes in the area of health care are contracting authorities.
- In Spain all bodies and entities governed by Spanish legislation on public procurement and administrative entities and common services of the health and social services are contracting authorities.
- The United Kingdom has enumerated the following entities: National Health Service Strategic Health Authorities, NHS Trusts, Regional Medical Service, Royal Hospital, Chelsea, Community Health Partnerships, Special Health Boards, Health Boards, the Welsh National Health Service Trusts, Local Health Boards. Bodies and National Health Service Strategic Health Authorities.

It is evident that Member States have different perceptions about the entities, which, in their respective health care systems, qualify as contracting authorities. Obviously, this can lead to a different application per Member State of the Directive in the field of health care.

CJEU case law limited to clear cases

The last decade the Court has been increasingly faced with procurement
disputes in the field of health care. A growing number of infringement proceedings in this area has been initiated by the Commission. Furthermore, since the financial interests involved are often substantial and the market for healthcare grows, there is an increasing number of disputes found to be worth fighting in courts. In a series of judgements the Court has ruled on compliance with EU public procurement rules in health care. *Oymanns* apart, this 'health care case law' incidentally deals with the concept of 'contracting authority', thus offering hints which helpfully complete the above-discussed Annexes.

From *Tögel* follows that the sickness fund for lower Austria is considered to be a contracting authority. [77] Under national legislation the Austrian social security institutions are required to reimburse to insured persons the costs of transport incurred by them or by members of their families when they have had to call on medical assistance. The relationship

[76] Available on http://ec.europa.eu/internal_market/publicprocurement/authorities_en.htm.
[77] *Tögel, supra* n. 27.

between the social security institutions and the transporting undertakings are governed by private-law contracts which must afford insured persons and members of their families adequate access to the benefits provided for by the law and under agreements. Thus, the Niederösterreichische Gebietskrankenkasse entered into framework agreements with the Austrian Red Cross, regional section for Lower Austria, and the Austrian Federation of Samaritan Workers, for the provision of patient transport of all three types. The reasoning of the Court on whether this concerned a Part A or Part B- services contract has already been discussed in paragraph 2.2.

In *Ambulanz Glöckner*, a case, which also concerned the provision of patient transport services, the question had been raised in German proceedings between Ambulanz Glöckner, a private undertaking established in Pirmasens and the administrative district Landkreis Südwestpfalz, a contracting authority, concerning its refusal to renew authorization for the provision of ambulance services.[78] This case has become renown for the Court's reasoning on the justified use of Article 106(2) TFEU (Article 86(2) TEC) (see par. 4.3). Based on this exception, the Court ruled that ambulance contracts could be awarded on the basis of prior authorization, without a tender procedure.

In *Contse* the Instituto Nacional de la Salud (the National Health Institute, 'Insalud') had issued two calls under the then applicable public procurement directive (92/50/EEC) for tenders for services of home respiratory treatments and other assisted breathing techniques in two Spanish provinces.[79] Contse SA, an oxygen-producing factory, submitted that 'Insalud had breached Articles 12 EC, 43 EC et seq. and 49 EC et seq., and Article 3(2) of [Directive 92/50] by including certain criteria and elements in the tendering specifications, special administrative clauses and technical specifications.' For example, Insalud had applied an admission condition which required the tenderer at the time the tender was submitted to have an office open to the public in the capital of the province where the service was to be provided. The Court ruled that Article 56 TFEU (old 49 TEC) precludes a contracting authority, such as Insalud, from applying this type of admission criterion. All the above findings are based on the assumption that Insalud is indeed a contracting authority.

It can be safely adduced from case *Medipac-Katzantzidis* that public hospitals in Greece are contracting authorities.[80] Venizelio-Pananio, which is the general hospital of Heraklion (Isle of Crete), had issued a tender for the supply of various surgical sutures. Medipac was one of the nine companies, which submitted a tender. The committee conducting the tendering procedure issued a recommendation to Venizelio-Pananio's Administrative Board, reiterating a suggestion from the surgeons of that hospital that the PGA type sutures proposed by Medipac be excluded. According to that recommendation, it had been found that knots done with PGA type materials slipped easily and closed prematurely, that needles frequently twisted or broke and that sutures did not hold sufficiently. The CJEU decided that, where

[78] Case C-475/99 *Ambulanz Glöckner* [2001] ECR I-8089.
[79] Case C-234/03 *Contse* [2005] ECR I-9315.
[80] *Medipac-Kazantzidis*, *supra* n. 7, confirmed in Case C-489/06 *Commission v Greece*, nyr.

proposed products, although bearing the CE marking, give rise to concern on the part of the contracting authority, such as Venizelio-Pananio, as to patients' health or safety, the principle of equal treatment of tenderers and the obligation of transparency preclude the contracting authority from being able itself to reject the tender in question. Since harmonization was in place (Directive 93/42 concerning medical devices, as amended by Regulation No 1882/2003), the contracting authority should, if it considered that those materials could jeopardize public health, inform the competent national authority and set the safeguard procedure of that Directive in motion.

In Italy regions and regional health associations are contracting authorities. In case C-119/06 *Commission v Italy*, the Commission initiated proceedings against Italy because the region of Tuscany and the Tuscan Aziende Sanitarie (public health authorities) had extended the duration of the regional framework agreement for the supply of healthcare transport services with the Confederazione delle Misericordie d'Italia, ANPAS - the Tuscan regional committee and the Croce Rossa Italiana - Tuscan division, without a tender procedure.[81] The Court dismissed the Commission's action for lack of proof. However, the reasoning of the Court with regard to the presence of a public service contract is interesting and will be discussed in paragraph 4.4 of this chapter.

Finally, in both *Commission* v. *Ireland* cases from 2007, 'classic' contracting authorities were involved: In *An Post* the Irish Minister for Social Welfare and in *Ambulance Services* the Dublin City Council.[82]

All these cases do offer some certainty about the authorities they deal with. The authorities concerned, however, did not present any particular difficulty as to their qualification as contracting authorities: they all concerned cases of straight-forward state controlled entities. This case law, nonetheless, offers little guidance – if at all – for more complex institutional settings. What about private hospitals funded by public funds (Belgium)? Do private hospitals in the UK and Ireland contracted by NHS Strategic Health Authorities qualify as contracting authorities? In the Netherlands do private health insurers (where affiliation is compulsory according to terms fixed by law) and private hospitals receiving funds from central government need to comply with the Directive? Currently, there are no general answers to these outstanding questions. As follows from a Dutch case study, which is examined in section 5 of this chapter, the answers may differ per individual entity, active in the field of health care.

4. Possible exceptions from tendering obligations in the field of health care

According to analysis above, whenever the health care service concerned is of cross-border interest and the purchasing entity qualifies as a contracting authority, the rules on public procurement should apply. This analysis, however, completely ignores the theoretical

[81] Case C-119/06 *Commission v Italy* [2007] ECR I-4557.
[82] *An Post, supra* n. 2, *Ambulance Services*, *supra* n. 42.

arguments according to which health care should not be subject to EU public procurement rules at all (4.1). These explain that there are, within EU Law, several means of justifying non-competitive tenders: Treaty exceptions and the overriding reasons of public interest (4.2), the accomplishment of some mission of general interest according to Article 106 (2) TFEU (old Article 86(2) EC) (4.3) and reasons inherent in the public procurement rules (4.4).

Arguments against the application of procurement rules and principles in the field of health care

More controversial than the technical procurement issues discussed above is the general question whether health care provision should be subject to EU public procurement rules at all. From the Feedback Report to the 2006 questionnaire of the Social Protection Committee follows that substantive arguments have been put forward against the general application of these rules to health care provision.[83]

First of all, public authorities doing public tenders in the field of health and social services are facing many difficulties according to the responses to the consultation. Drafting tenders is reported as being a difficult and demanding task. Especially, public authorities (and very often municipalities) have difficulties to define the content of the services and to develop requirements in a detailed way, all the more since the services will have to be personalized to the specific needs of each user. These difficulties are reinforced by the fact that public authorities do not necessarily know in detail the needs and specificities of health and social services. Therefore, the risk of public tenders focusing on prices has been often mentioned.[84]

Furthermore, the public procurement rules are seen as not flexible enough regarding inter-municipal cooperation, which in principle falls under the scope of the Directive, resulting from the restrictive concept of 'in-house' contracts.[85] Moreover, the application of public procurement is reported as changing the traditional type of partnership relationship between public authorities and providers into a competitive one. As a result, it has been put forward that private initiatives in social services that require public financing may be difficult to carry out within the framework of public procurement legislations.

Moreover, the negative effect on establishing long-term trust relationships with suppliers and other partners has been raised, which may ultimately lead to a disruption of the continuity of a public service. Other issues concern the increased transaction costs and delays. The administrative burdens placed on small organizations for organizing a tender procedure. Contributors indicate that providers have experienced increased paperwork in the last few years, manifold bureaucratic requirements for applications and reporting. These

[83] Social Services of General Interest: Feedback Report to the 2006 questionnaire of the Social Protection Committee, p. 10-12, available at: http://ec.europa.eu/employment_social/spsi/docs/social_protection/2008/feedback_report_final_en.pdf.
[84] *Ibid* p. 10.
[85] *Ibid* p. 11.

increased requirements bind a lot of valuable resources of organizations, which is especially difficult for small associations, NGOs etc, often active in the field of health care.

In light of all these issues, the positive effects of public procurement applied to health and social services (more quality, more choice and reduced prices) are put in question by some contributors. In a perfect market competition may indeed contribute to making the activities more effective and to cost savings, but there are several problems in the field of social welfare and health care that are caused by market failures, particularly by asymmetric information.

It is not easy to rebuff the above arguments. The Commission, however, despite declaring itself concerned about them, favours a different approach. Following a Communication from the Commission on 'A Single Market for 21st Century Europe' [86], a Staff Working Document 'Towards the application of public procurement rules to social services of general interest' the Commission confirms its attachment to the application of the public procurement rules and principles in the area of health care. If a public authority decides to 'externalize' a social service of general interest against remuneration, it has to follow the Community law rules on the award of public service contracts. [87] In the framework of the consultation process launched following its Communication on Social Services of General Interest of April 2006, the Commission received a number of questions concerning the application of the public procurement rules to social services of general interest. The Staff Working Document provides answers to these queries. In case of Part B-services (for example: health and social services, educational services etc.), the 'light' procurement regime is applicable. As we have seen in paragraph 2.3, contracting authorities should also live up to the transparency principle when a Part B-contract is of 'certain cross-border interest.'

Treaty exceptions and overriding reasons

Article 51 TFEU (old Article 45 TEC), which is extended by Article 62 TFEU (old Article 55 TEC) to cover the chapter of services, states that the Treaty provisions shall not apply 'so far as any given Member State is concerned, to activities which in that State are connected, even occasionally, with the exercise of *official authority*.'[88] The Court has interpreted the official-authority exception narrowly. Furthermore, Article 52 TFEU (old Article 46 TEC) in the chapter on services provides that provisions of those chapters 'shall not prejudice the applicability of

[86] Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions. Services of general interest, including social services of general interest: a new European commitment. 20.11.2007 COM (2007) 725 final, p. 11.

[87] Commission staff working document. "Frequently asked questions concerning the application of public procurement rules to social services of general interest." SEC(2007)1514 of 20.11.2007.

[88] Case 2/74 *Reyners* v. *Belgium* [1974] ECR 63. Official authority is that which arises from the sovereignty and majesty of the State; for him who exercises it, it implies the power of enjoying the prerogatives outside the general law, privileges of official power and powers of coercion over citizens.

provisions laid down by law, regulation or administrative action providing for special treatment for foreign nationals on ground of *public policy, public security or public health*.' Recital 6 of the Public Sector Directive provides for a similar exception: 'nothing in this Directive should prevent the imposition or enforcement of measures necessary to protect public (…) health, human and animal life (…).' However, a) the very recital states that these measures should be in conformity with the Treaty and b) no corresponding provision is to be found in the operative part of the Directive. Therefore, this recital should be seen as a cross-reference to the Treaty express exceptions. In relation to healthcare services, *public health* is the most relevant Treaty exception.

Besides the express exceptions contained in the Treaty, the Court has developed a large body of 'overriding reasons of general interest' which may justify national restrictions on the freedom of establishment and services.[89] Until recently, the relevance of these exceptions for justifying the infringement of the provisions of the Directive or the transparency obligation in EU procurement law practice had not been acknowledged. Nonetheless, there is a trend that these exceptions are being considered as a possible justification for these types of infringements. In public procurement cases the Court is prepared to recognize Treaty exceptions and overriding reasons. This is especially visible in recent case law of the Court. In *Commission v Ireland (ambulance Services)*[90] Advocate General Stix-Hackl examined whether Ireland, which did not advertise the award to supply emergency services, could in that respect rely on 'one of the Treaty rules providing for a general exemption of measures of the Member States from the application of primary law, whether one of the grounds of justification expressly provided for in the Treaty or a ground of justification recognized by case law.'[91] As a matter of principle, the Advocate General considered that the overriding reasons should also be applied in relation to procurement law. Ireland was unable to demonstrate that grounds of justification or requirements in the general interest, recognized by the Court, such as consumer protection, were at stake. In *Commission* v. *Italy* (service concessions for horse-betting), the Italian Government argued that the automatic renewal of 329 licences for horse-betting operations without inviting any competing bids was 'justified by the need to ensure continuity, financial stability and a proper return on past investment for licence holders as well as the need to discourage recourse to clandestine activities, until the existing licences could be reallocated on the basis of tendering procedures.'[92] The Court considered that the renewal of the licences may (i) be recognized as an exceptional measure, as provided for in Articles 45 and 46 EC, or (ii) justified in accordance with case law of the Court for overriding reasons of general interest. Regarding overriding reasons of general interest, the Court referred to

[89] For example, Case C-19/92, *Kraus*, [1993] ECR I-1663, para 32; Case C-55/94, *Gebhard*, [1995] ECR I-4165, para. 37; and Case C-243/01, *Gambelli*, [2003] ECR I-13031, paras. 64-65.
[90] *Ambulance Services*, *supra* n. 42.
[91] *Ibid*, Opinion of the A.G., paras. 86 et seq. The Court concluded that there was no public contract. It therefore did not need to address the issues discussed here.
[92] Case C-260/04*, Commission* v. *Italy*, [2007] ECR I-4165*,* para. 15.

consumer protection and 'the prevention of both fraud and incitement to squander on gaming', as well as to the need to preserve public order.[93] However, the renewal of the licences without putting them out to tender was 'not an appropriate means of attaining the objective pursued by the Italian Republic, going beyond what was necessary in order to preclude operators in the horse-race betting sector from engaging in criminal or fraudulent activities.'[94]

An example of the way public health has proved antagonistic to the full application of the procurement rules is offered by the case *Medipac-Katzantzidis.*[95] In this case the Court acknowledged with reference to settled case law 'that the objective of the protection of public health constitutes an overriding public-interest requirement entitling Member States to derogate from the principle of the free movement of goods provided that the measures taken comply with the principle of proportionality.'[96] According to the Court the suspension of a tendering procedure for the supply of medical devices may lead to delays liable to give rise to problems in running a hospital such as Venizelio-Pananio. Consequently, the Court considered that in a situation of urgency, i.e. if the implementation of such a safeguard procedure gives rise to delays liable to jeopardise the operation of a public hospital and thereby public health, a hospital such as Venizelio-Pananio is entitled to take all interim measures required to enable it to procure the medical devices necessary for its operation. However, it must be able to show that there is a situation of urgency justifying such derogation from the principle of free movement of goods and demonstrate that the measures taken are proportionate. [97]

Services of General Economic Interest

Services of general economic interest ('SGEI') are referred to in Articles 14 and 106(2) TFEU. Article 14 TFEU confers responsibility upon the Community and the Member States to ensure, each within their respective sphere of competences, that their policies enable SGEI to fulfil their missions. Article 106(2) TFEU implicitly recognizes the right of Member States to assign specific public service obligations to economic operators. Providers of SGEI are exempted from application of the Treaty rules to the extent that this is necessary to allow them to fulfil their mission to pursue activities of general interest. In the Protocol on SGEI annexed to the Treaty of Lisbon, SGEIs are defined as 'services, both economic and non-economic, which the public authorities classify as being of general interest and subject to

[93] See, in particular, Joined Cases C-338/04, C-359/04 & C-360/04, *Placanica* [2007] ECR I-1891.
[94] *Commission* v. *Italy*, *supra* n. 92, paras. 34-35.
[95] *Medipac-Kazantzidis*, *supra* n. 7.
[96] See Case 120/78 *Rewe-Zentral* [1979] ECR 649 ('*Cassis de Dijon*'), para. 8; Case C-270/02 *Commission* v. *Italy* [2004] ECR I-1559, paras. 21 and 22; and Joined Cases C-158/04 and Case C‑159/04 *Alfa Vita Vassilopoulos and Carrefour-Marinopoulos* [2006] ECR I-8135, paras. 20-23.
[97] *Medipac-Kazantzidis*, *supra* n. 7, paras. 60-62.

specific public service obligations.'[98] It is the responsibility of public authorities, at the relevant level, to decide on the nature and scope of SGEI.[99] It is therefore difficult to define one single concept of SGEI, which encompasses the different situations existing in the various Member States. The Court has considered, *inter alia*, the following activities as being SGEIs: the operation of a river port which handles the majority of river traffic in goods in a Member State,[100] the establishment and operation of a public telecommunications network,[101] the operation of television services[102] and of certain transport lines,[103] employment recruitment[104] and basic postal services.[105] In a number of cases the Court has positively applied Article 106(2) TFEU, holding that an exclusive or special right was required for the undertaking in question to perform the universal services under economically acceptable conditions.[106]

The Court has not yet had the opportunity to declare that Article 106(2) TFEU may derogate from public procurement rules and the transparency obligation. However, in *Ambulanz Glöckner* the Court was asked to rule on the application of Article 106(2) TFEU in relation to the authorization to provide ambulance services. [107] The Landkreis involved relied on former Article 86(2) EC for justifying that ambulance contracts were awarded to public ambulance service providers on the basis of authorizations – not tenders. It argued that some measure of protection of the public ambulance service against competition from independent operators was necessary. According to the Landkreis emergency transport services, which must be provided 24 hours a day throughout the territory, require costly investments in equipment and qualified personnel. Such investment may be paid out by the award to the same operations – without any competitive tender – of the authorization to operate also on the non-emergency transport. According to the Court, 'the possibility which would be open to

[98] On the concept of SGEIs and its implications on EU law, especially after the entry into force of the Lisbon Treaty, see, among many, the contributions contained in U. Neergaard, R. Nielsen & I. Roseberry (eds), *Integrating Welfare Functions into EU Law – From Rome to Lisbon* (Copenhagen: DJØF Publishing, 2009); M. Krajewski, U. Neergaard, J. Van de Gronden (eds) *The Changing Legal Framework for Services of General Interest in Europe – Between Competition and Solidarity* (The Hague: Asser, 2009); J. van de Gronden (ed) *EU and WTO Law and Services – Limits to the Realization of General Interest, Policies within the Services Markets?* (Austin etc: Kluwer, 2009).

[99] In Case T-289/03, *BUPA* [2005] ECR II-741, the CFI recognized explicitly that Member States have a wide discretion in defining what services on their territory are to be considered as SGEI. The Commission nonetheless scrupulously examines whether a Member State has committed "a manifest error" when defining a certain service as SGEI. It does so in particular in State aid cases.

[100] Case 10/71, *Port of Mertert*, [1971] ECR 730, para. 11.

[101] Case 41/83, *Italy* v. *Commission*, [1985] ECR 888, paras. 29-33.

[102] Case 155/73, *Sacchi*, [1974] ECR 409.

[103] Case 66/86, *Ahmed Saeed*, [1989] ECR 853, para. 55.

[104] Case C-41/90, *Höfner*, [1991] ECR I-2017, para. 24.

[105] Case C-320/91, *Corbeau*, [1993] ECR I-2568, para. 15.

[106] In all these cases the Court accepted the argument that the exclusive right protected the undertaking in question against the risk of cream skimming, leaving them with the least profitable services. See *Corbeau*, *supra* n. 97; Case C-67/96, *Albany*, [1999] ECR I-5751; Case C-209/98, *Deutsche Post*, [2000] ECR I-3743.

[107] *Ambulanz Glöckner*, *supra* n. 78.

private operators to concentrate, in the non-emergency sector, on more profitable journeys could affect the degree of economic viability of the service provided by the medical aid organizations and, consequently, jeopardize the quality and reliability of that service.'[108]

However, like every exception, Article 106(2) TFEU has to be interpreted strictly. The restriction of the free provision of health services must be proportionate to the general economic interest pursued. Therefore it must be concluded that only in very exceptional cases may a contracting authority successfully rely on Article 106(2) TFEU to justify a breach of transparency obligations with regard to health care services. It should be also noted that *Glöckner* is the only case in which Article 106(2) has been successfully pleaded in order to avoid the application of the procurement rules – and that it was decided before the '*Transparency* case law' had been fleshed-up.

No public service contract involved

According to and for the purposes of the Public Sector Directive, public contracts are 'contracts for pecuniary interest concluded in writing between one or more economic operators and one or more contracting authorities (…).'[109] In summary, the definition of a public contract includes three elements: *a contract, in writing, for consideration* (or in other words: 'for pecuniary interest'). If one of these constitutive elements is absent, there is no public service contract involved and the Directive does not apply. Especially, the notion of 'for consideration' has given rise to a considerable amount of case law. The Directive does not define 'consideration.' In that respect there are two cases in the field of health care procurement, which are relevant.

In case C-119/06 *Commission v Italy* the Court had to decide whether Italian public health authorities had lawfully extended the duration of the regional framework agreement for the supply of healthcare transport services.[110] These were carried out by voluntary/not for profit associations such as the Red Cross, the Samaritans etc. Italy argued before the Court that the services provided did not qualify as a public service contract in terms of the Directive, since the involved service providers did not receive any remuneration in return for their services: they only received a reimbursement for their fixed costs. With reference to settled case law,[111]in which the Court interprets the definition of contracting parties' obligations very

[108] *Ibid* para. 61.

[109] Article 1(2)(a) Public Sector Directive.

[110] *Commission* v. *Italy*, *supra* n. 81.

[111] Case C-399/98, *Ordine degli Architetti delle province de Milano e Lodi* v. *Comune di Milano,* [2001] ECR I-5409. In this ruling, the city of Milan had given developers permission for a development scheme to build the exterior of the world-known theatre. The Court ruled that there was a contract, although the agreement was governed by public law and involved the exercise of public law powers. Advocate General Léger had reasoned that if something is provided without benefit to the provider there is no potential for the favouritism that the Directives seek to prevent.

widely, the Court rejects this argument. [112] The Court rules that the element of consideration is fulfilled when services are rendered on behalf of – and paid by – a contracting authority by virtue of a contract.[113] The Court takes into consideration the fact that the service providers do not only receive payment for specific services they offer, but also for keeping their helicopters on "stand-by.'[114] To the extent that the amounts received do not strictly correspond to the costs incurred for the provision of services, the element of 'consideration' has been fulfilled.[115] The foregoing means that any approximate calculation of remuneration which is not tailored to reflect the exact cost of a given service – i.e. the usual kind of arrangements in the field of healthcare – gives rise to a public contract even if it is awarded to a non-profit organization.

Despite the large definition given by the Court to the concept of consideration and, as consequence, to the existence of a contract, there are nonetheless service relations which do not qualify as being contractual. In *Commission v Ireland (ambulance services*) the Commission argued that Dublin City Council ('DCC') had allegedly awarded a Part B-service contract to provide emergency ambulance services to the Eastern Regional Health Authority without undertaking any prior advertising.[116] According to the Commission, DCC and the Authority agreed to enter into a service-level agreement and that a contract was drafted to that end. Therefore, DCC provided emergency ambulance services at the behest of the Authority and for remuneration.[117] The Court decided differently. According to the Court 'it is conceivable that DCC provides such services to the public in the exercise of its own powers derived directly from statute, and applying its own funds, although it is paid a contribution by the Authority for that purpose, covering part of the costs of those services.'[118] According to the Court, the mere fact that funding arrangements exist between two public bodies in respect of such services does not imply that the provision of the services concerned constitutes an award of a public contract.[119] Two elements seem to have determined the Court's judgment in this case, although none is clearly expressed in the judgment (by the Grand Chamber). First, that by making arrangements for the provision of ambulance services the DCC was honoring its statutory obligations – not arranging some 'fantasy' service provision. Second, that none of the entities involved seemed to be of a commercial nature.

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[112] The Commission interprets the definition of the contracting parties obligations also very widely. 'All forms of consideration moving from the contracting authority and capable of valuation in money terms satisfy the requirement of pecuniary consideration', according to the Commission in its Guide to the Community Rules on Public Procurement of Services, *supra* n. 10, p. 11-12.

[113] *Commission v Italy*, *supra* n. 81, para. 47.

[114] *Ibid* para. 48.

[115] *Ibid* para. 50: 'Dans les circonstances précises de l'espèce, la méthode de paiement prévue par l'accord-cadre de 2004 dépasse donc le simple remboursement des frais encourus. Dans cette mesure, il convient de considérer que cet accord-cadre prévoit une contrepartie des services de transport sanitaire qu'il vise.'

[116] *Ambulance Services*, *supra* n. 42.

[117] *Ibid* para. 32.

[118] *Ibid* para. 35.

[119] *Ibid* para. 37.

5. A case study: Do public hospitals in the Netherlands qualify as contracting authorities?

It has been explained above that the applicability of the procurement rules in the field of health care, depends on the assessment whether the health purchaser qualifies as a contracting authority in terms of the Public Sector Directive. However, in paragraph 3 we have reached the conclusion that such assessment is casuistic and, often, unpredictable. The legal uncertainty ensuing may be illustrated by reference to the *Amphia* series of cases, in the Netherlands. Until 2004, the Dutch general hospitals, united in the Cooperation Dutch Hospitals were not considered to be contracting authorities (with the exception of academic-teaching hospitals). The *Amphia* case, led to proceedings at the Dutch Supreme Court and four years of intensive debate among lawyers and policy makers in the Netherlands. First, a short introduction into the Dutch health care system and into the current procurement practice in the field of health care in the Netherlands is given (5.1). Then we present (5.2) and analyze (5.3) the Amphia cases.

A short introduction into the Dutch health care system and into procurement practice in health care in the Netherlands

In January 2006 the Netherlands established a new health care system, aiming at introducing a competitive market and increasing patient choice. Currently, private health insurers operate the system. [120] The insurers are required to provide a standard benefits package covering medical care.[121] The Dutch health insurance system is financed by a (i) income-related contributions and (ii) premiums paid by the insured.[122] Contributions are collected centrally and distributed by the so-called Health Insurance Fund among insurers on a risk-adjusted capitation formula. A system of risk equalization enables the acceptance obligation and prevents direct or indirect risk selection. As for the organization of the delivery of health care, the private health insurers are directly in contact with physicians. General Practioners receive a payment for each patient on their practice list and a fee per

[120] Prior to 2006, a dual system of private a public insurance existed. People with earnings above approximately €30,000 per year and their dependants (around 35% of the population) were excluded from statutory coverage provided by public sickness funds and could purchase cover from private health insurers.

[121] Statutory coverage includes: care by general practitioners (GPs), hospitals and midwives; hospitalization; dental care (up to the age of 18; coverage from age 18 is confined to specialist dental care and dentures); medical aids; medicines (not all medicines; sleeping pills nor for example are not covered); maternity care; ambulance and patient transport services; paramedical care (limited physiotherapy/remedial therapy, speech therapy, occupational therapy and dietary advice).

[122] The income-related contribution is set at 6,5% of the first € 30.000 of annual taxable income. Employers reimburse their employees for this contribution and employees pay tax on this reimbursement. The Dutch insured pay a flat-rate premium (set by insurers) to their private health insurer. The Dutch government has created a safety net for low-income citizens if the average flat-rate premium exceeds 5% of their household income. Furthermore, the Dutch government pays for the premiums of children up to 18 years old.

consultation. The majority of specialists in the Netherlands work in hospitals. Two-thirds of hospital-based specialists are self-employed, organized in partnerships and paid on a fixed fee for services. Hospital budgets are developed using a formula that pays a fixed amount per bed, patient volume and number of licensed specialists. Additional funds by the government are provided for capital investment, although hospitals are increasingly encouraged to obtain investments via the private market. Recently, a new system of payments was introduced: the Diagnosis Treatment Combinations ('DTC'). A DTC consist of a description of a medical service and the price of this treatment, which a hospital delivers. In 2008, 10% percent of all hospital services were reimbursed on the basis of DTCs. In the future, it is expected that most care will be reimbursed using DTCs. However, there is still considerable debate about the desired speed of further liberalization of the hospital market. In the future hospitals may have greater freedom in negotiating the price and quality of DTCs. The quality of care is guaranteed through legislation regarding professional performance. The Netherlands Health Care Inspectorate protects and promotes health and healthcare by ensuring that care providers, care institutions and companies comply with these laws and regulations.

In the Netherlands there are no figures concerning the extent to which EU public procurement rules are applied in the field of health care. Therefore, it is difficult to conclude whether the procurement rules are at all of influence on the organization and provision of health care in the Netherlands. In 2008 a statistical study was published concerning the compliance of eight academic hospitals in the Netherlands with the public procurement rules.[123] Since Dutch academic hospitals qualify as contracting authorities under the Public Sector Directive, they have to comply with the procurement rules, when they purchase works, supplies and services. The outcome was, especially compared to 2004, disappointing. Only 57% of contracts (in 2004: 59%) were tendered in compliance with the directive. In total 47% of the public services contracts (for example on consultancy) and 67% of the public supplies contracts were tendered.[124] With regard to the construction and exploitation of works the compliance was the highest, i.e. 72%.[125] In the field of social services, all municipalities in the Netherlands are under the Social Support Act now responsible for setting up social care and support (mixed Part A and Part B-services). This Act has introduced a new scheme for all

[123] Nalevingsmeting Europees Aanbesteden 2006. Onderzoek naar naleving van Europese aanbestedingsregels in Nederland. By Significant B.V., November 2008. http://www.ez.nl/Actueel/Kamerbrieven/Kamerbrieven_2008/November_2008/Nalevingsonderzoek_aanbesteden.

[124] Compared to 2002 and 2004 the compliance rate was lower, especially in the field of public services contracts. Nonetheless, figures show that the amount of public procurement procedures has increased, possibly due to the increased splitting of contracts into different parcels.

[125] This has to do with the important role the Netherlands Board for Healthcare has performed in the accommodation of intramural healthcare. Until 2008 hospitals had to require both a license and a building permit from the Board for new construction projects and major renovations under the Healthcare Institutions Act. The Board considered applications for building permits by checking compliance with the procurement rules. Currently, government involvement in healthcare construction diminishes and hospitals and other healthcare institutions will have to handle their property investments by earning back those investments by means of their activities. See http://www.bouwcollege.nl.

Dutch citizens covering care and support in cases of protracted illness, invalidity of geriatric diseases. Many Dutch municipalities have decided to contract this type of care out after a procurement procedure. This has led to a great amount of procurement disputes. In the Dutch parliament the general question was raised whether social services should be subject to procurement rules at all.

The Amphia cases: Does a general hospital in the Netherlands qualify as a contracting authority?

Amphia, founded after a merger of three hospitals, has, according to its statutes, as its objective according to its statues to "research, treat, nurse and take care of the ill." In April 2002 Amphia decided to install a new kitchen and food distribution system in its hospitals. It decided to purchase new food distribution trolleys. The total value of the contract was above the then applicable threshold for supply contracts. However, Amphia did not organize a procurement procedure in compliance with the former Supplies Directive 93/36/EEC, but invited several suppliers, who are active in that business, to take part in a business presentation. Following these presentations, only two undertakings were invited to take part in the actual price negotiations. Sortrans B.V. ('Sortrans'), who had until then acted as the main supplier of these trolleys, submitted an offer, which was rejected by Amphia.

In the proceedings, initiated by Sortans, before the District Court of Breda, Sortans submitted that Amphia qualifies as a contracting authority and therefore should have organized a tender in accordance with the Supplies Directive. This plea was successful. Both the District Court[126] and the Court of Appeal in Den Bosch[127] ruled that Amphia indeed qualifies as a contracting authority. First, the courts positively answered the question whether Amphia fulfills *specific purpose of meeting needs in the general interest,* which *do not have an industrial or commercial character.* In that respect both courts reasoned that the objective of Amphia consists of meeting needs in the general interest, since it deals with public health. Although Amphia stands in competition with other hospitals, this does not prevent an institution from meeting needs in the general interest. Moreover, the competition was restricted in a sense that, at that time, 90% of the hospitals tariffs were regulated in the Netherlands. Furthermore, sickness funds were obliged to accept Amphia as partner. Second, the Court of Breda decided that Amphia is *an entity, financed, for the most part*, by the state, regional or local authorities or other bodies governed by public law. [128] Amphia had submitted that, although, it was financed for the most part (60%) out of sickness funds premiums and 40% out of private health insurance premiums, these premiums could not be regarded as financed by the state, since these premiums were based on the principle of solidarity, which means that the premium was related to the income of the insured and not related to the

[126] Voorzieningenrechter Rechtbank Breda, KG ZA 04-486, LJN: AR7227.
[127] Gerechtshof 's-Hertogenbosch, C0500057, LJN: AU4635.

insured activities or risks. Both courts ruled that sickness funds were obliged to contract hospitals and there was no contractual relationship between the former sickness funds and hospitals. Finally, Amphia had put forward that the condition of *'subject to management supervision by the state, regional or local authorities or other bodies governed by public law'* was not being fulfilled, since the state did not intervene with the decision which supplier would obtain the contract to supply the trolleys. The Court of Breda, however, decided that, by regulating and supervising quality, tariffs, exploitation, and renovation works, the state supervised a hospital in such a way that a hospital could not be considered independent in that respect.

In its ruling of 1 June 2007 the Supreme Court set aside the decision of the Court of Appeal.[129] In a relatively short judgment it considered that the Court of Appeal should have taken into consideration the factual circumstances, in which Amphia operates. The statutes should not be decisive but instead the climate in which Amphia operates should be given consideration in order to answer the question whether Amphia fulfills *specific purpose of meeting needs in the general interest*, which *do not have an industrial or commercial character.* In that respect the Supreme Court considered that from 1 January 2003 onwards, general hospitals in the Netherlands operate in a climate of competition and that they are increasingly in the possibility to compete with other hospitals on prices. Moreover, although Amphia's main aim is to generate as much profits as possible, it is managed (and by health insurers led) on the basis of 'output, effectiveness and profitability.' Therefore, together with the fact that general hospitals are increasingly responsible for exploitations risks, a public hospital is not an entity, which fulfills *specific purpose of meeting needs in the general interest,* which *do not have an industrial or commercial character.* With regard to the question whether Amphia is *an entity, financed, for the most part,* by the state, regional or local authorities or other bodies governed by public law, the Supreme Court decided that there exists a contractual relationship between the former sickness funds and public hospitals, since in return for the premiums, hospitals render care based on Article 44 of the former Sickness Fund Act. According to the court, financing by the state can only be the case when hospitals receive payments for their activities, without rendering anything in return.[130] The Supreme Court referred the case to the Court of Appeal in Arnhem to decide on the merits of the case. Meanwhile, the Minister of Health advised public hospitals for the sake of legal certainty to apply the procurement rules in the meantime.[131]

The Court of Appeal only scrutinized the third condition under Article 1(9), which is that

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[128] The Court of Appeal found that it was not necessary to scrutinize possible fulfilment of this condition and the third condition 'financed by the state.'

[129] Hoge Raad, C06/022HR, LJN: AZ9872. As the highest court in fields of civil, criminal and tax law in the Netherlands, the Supreme Court examines only whether a lower court observed proper application of the law in reaching its decision. At this stage, the facts of the case as established by the lower court are no longer subject to discussion. After ruling, it will refer to a Court of Appeal, which will decide on the merits of the case.

[130] J.M. Hebly, 'De Ziekenhuisparabool', *Tijdschrift* Aanbestedingsrecht, June 2008.

[131] Http://www.minvws.nl/kamerstukken/staf/2007/aanbestedingsplicht-ziekenhuizen.asp.

of the Directive applies to an entity, which must be either *financed* or *supervised* or *appointed* by another contracting authority. With reference to the cases *Commission/France* and *Truly* for this criterion to be fulfilled, there should be, according to the court, dependency, which amounts to a significant influence on its management and which permits the public authorities to influence or interfere with the procurement procedures.[132] The Court of Appeal decided that this was not the case. The applicable laws only related to the supervision on the construction of hospitals buildings, the purchase of medical equipment and the budget of hospitals, but did not concern the actual choice of a trolley supplier. Nor did the regulation of quality by Netherlands Health Care Inspectorate and other laws concerning the quality and safety of food do so. The laws and regulations are of a general character, in other words, they concern the Dutch health care system in general and not specifically Amphia only. These laws and regulations rather create a framework, in which hospitals (which enjoy policy competences) such as Amphia need to organize health care.

Table 1: comparison of the different Amphia judgments

Criterion for Contracting Authority	District Court of Breda /Court of Appeal Den Bosch	Supreme Court	Court of Appeal Arnhem
Specific purpose of meeting needs in the general interest?	YES because: Public health main objective tariff regulation compulsory contracting	NO because: Climate of competition Hospitals managed on "output, effectiveness and profitability."	
Financed for the most part by state?	YES because: Financed for 60% out of sickness funds No contractual relationship between funds and hospitals	NO because: Contractual relationship exists Hospitals render health care in return for premiums	
Supervised by the state?			NO because: Not a significant influence on its management and influence or interference with the outcome of tender procedures

[132] *Commission v France*, *supra* n. 61, para. 59.

Analysis

It can be concluded following the *Amphia* cases that not all public hospitals in the Netherlands qualify as contracting authorities. However, a general conclusion that all public hospitals do not qualify as contracting authorities has not been drawn. On the contrary, the Minister of Health has responded to parliamentary questions that this case law has left some questions unanswered.[133] Public hospitals may, depending on the circumstances, very well qualify as contracting authorities. In other cases than the *Amphia* case the condition of 'subject to management supervision' could be fulfilled. For instance, when the state or a public body significantly influence investment decisions. But based on the current applicable Dutch legislation this will not often be the case. According to the Minister current laws and regulations concern the admission of health care institutions and laws concerning the quality of care. This does not result into supervision in terms of the Directive, since they do not create influence or interfere with procurement procedures.[134]

Interestingly, neither the Supreme Court nor the Court of Appeal Arnhem decided to make a preliminary reference to the CJEU. In his conclusions Advocate General Keus considered the relevance of a possible reference.[135] On the one hand, he acknowledged the uncertainty, which exists with regard to the fulfillment of the 'financed by' criterion in relation to other health care entities financed by sickness funds premiums.[136] On the other hand, these cases have been decided under the former Dutch heath care system, which was set up around sickness funds and private health insurers. Since the Dutch health care system has been reformed, a preliminary reference in the *Amphia* case would have concerned the former health care system and would have only limited relevance for the future. Furthermore, it is important to note that the Court of Breda, the Court of Appeal Arnhem and the Supreme Court have all made extensive references, in their rulings, to settled case law of the CJEU. However, this case law was interpreted and applied in a different manner. Whereas, the Court of Breda (and the Court of Appeal Den Bosch implicitly) decided, with reference to *University of Cambridge*[137] that Amphia qualifies as a contracting authority, the Supreme Court and Court of Appeal Arnhem came to a different conclusion by applying *University of Cambridge, Agora, Truley and Commission v France.*[138] The question remains whether *Oymanns* could have changed the outcome in the *Amphia* cases. In other words, is the Dutch

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133 Http://www.minvws.nl/kamerstukken/staf/2007/aanbestedingsplicht-ziekenhuizen.asp. Letter of 26 January 2009.

134 Http://www.minvws.nl/kamerstukken/staf/2007/aanbestedingsplicht-ziekenhuizen.asp. Letter of 23 April 2009.

135 Conclusie A-G Keus, C06/022HR, LJN AZ9872.

136 Currently, uncertainty evolves around the question whether the so-called 'care offices' ("Zorgkantoren") are considered to be contracting authorities. Care offices are responsible for the implementation of the General Exceptional Medical Expenses Act (AWBZ). They have been set up by the jointly operating care insurers, but operate independently.

137 *University of Cambridge, supra* n. 59.

case law in line with the recent *Oymanns* ruling? As articulated on many occasions (and again in *Oymanns*) by the Court the concept of a public authority should be interpreted in a functional and broad manner. Both the Supreme Court and the Court of Appeal Arnhem have stressed the fact that the Dutch health care system is undergoing transition, gradually reducing State intervention to a minimum. Both courts had to apply Article 1(9) and its case law to a privatized health care system. It can be generally concluded that privatization of health care decreases the application of public procurement law. The conclusion that under these circumstances the EU public procurement rules are not applicable is reasonable. However, by doing so the Dutch courts have interpreted 'financed for the most part' differently than the CJEU has done in *Oymanns*. By scrutinizing the specific funding of the German health care system and the German laws, the Court concluded that a contractual relationship between the sickness funds and the insured was not present. The Supreme Court ruled in the opposite direction, by stating that, based on Dutch law, the sickness funds render health care in return for the received premiums. Therefore contractual consideration between the funds and the insured exists. Notwithstanding the differences between the two health care systems, the *Amphia* outcome can be seen as being contrary to the *Oymanns* decision with regard to the interpretation of the 'financed for the most part' condition. Therefore, despite the changes which the Dutch health care system currently undergoes, a preliminary reference would have been appropriate. It could have especially created more legal certainty with regard to the applicability of procurement rules to national health care systems, which are (semi-) privatized.

6. Conclusions

In 2009 the German Federal Court (FDC) had to decide whether emergency rescue services are subject to public procurement law.[139] In the region of Saxony, several Saxon municipalities provide for rescue services. These services are often delegated to private entities. The question was raised whether this alliance was obliged to apply public procurement rules to their tenders. The FDC ruled that since emergency services qualify as public service contracts, they should be tendered in accordance with the rules of the Directive.[140] In that respect the FDC took a functional approach and set aside national technicalities in administrative law. This goes in the opposite direction from *Amphia*. *Amphia* itself would have been decided differently had it not been brought to the Dutch Supreme Court. Thus, there is no general answer possible to the core question of this contribution: If, how and to what extent EU public procurement rules affect the national health care systems.

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[138] *Agora, supra* n. 55, *Adolf Truley supra* n. 56 and *Commission v France, supra* n. 61.

[139] Bundesgerichtshof, Ruling from 29 June 2009, BvR 2959/07.

[140] The Higher Regional Court in Düsseldorf had decided differently. According to this Court, the type of contract did not contain an obligation to provide a service but included a delegation of the exercise of official authority. Higher Regional Court Düsseldorf, Decision from 5 April 2006, VII-Verg 7/06.

Certainly, it can be concluded that, EU public procurement rules increasingly affect national health care systems. However, the answers to the question *how* and *to what extent* are unclear. Different outcomes are to be expected not only between different Member States but also within a single Member State. Depending on the judicial and constitutional system of each Member State internal differences will eventually be phased out, but it will take much longer to streamline the application of the relevant criteria at the EU level – especially since the healthcare systems of Member States are, and will be, in constant transition. The resulting variable geometry and legal uncertainty is clearly against the idea of a single market in the area of healthcare procurement, especially against the overriding principle governing procurement in the EU, that of transparency (i.e. there is an important lack of transparency at the level of the applicable rules). This is an unsatisfactory situation.

What are possible means for the EU to circumscribe uncertainty? How to clarify the scope of public procurement rules in relation to health care? A first step forward would consist of an up-dated and complete version of Annexes III and IV to the Public Sector Directive- preferably in English. This list should be closely monitored by the Commission and should be kept up-to-date by including the results of both European and national case law. Second, the Commission may decide to clarify at the level of the services by, through a text of soft law, defining the content of services of general interest in the field of healthcare. Furthermore, issuing a soft law document concerning specifically the criteria for the application of procurement in healthcare could be helpful. In this document the Commission can chose to clarify the *Transparency* case law in relation to health care. On a more general level, the EU could strive for common solutions through coordination or OMC. This could also provide a platform, whereby best practices in the field of health care procurement could be exchanged. Coordination in the field of health care, already in place,[141] is expected to intensify once the draft Patients Rights Directive becomes enacted.[142] Such coordination could also extend to procurement practices. By all means, uniform application of EU public procurement in the field of health care remains problematic, since both the organization and financing of national health care systems and public procurement in health care are not harmonized. However, for sake of transparency and legal certainty a minimum level of coordination is necessary, in order to keep the competition on these public markets healthy!

[141] See e.g., T. Hervey & L. Trubek 'Freedom to Provide Health Care Services in the EU: An Opportunity for "Hybrid Governance" (2007) 13:3 *The Columbia Journal of European Law* 623-647.
[142] COM(2008) 414.

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